

The perceptions of commune health workers about an education strategy received for
counselling fathers about infant and breastfeeding involvement

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Dedication

This thesis is dedicated to my family.

I couldn't have done this without your patience, support and help.

Thank you.

Abstract

Objective

To evaluate the perceptions of healthcare workers in Vietnam about the efficacy of a continuing education strategy about father involvement and breastfeeding counselling.

Design

One group, post-test only, quasi-experimental design

Method

A questionnaire based on Social Cognitive Theory (SCT; Bandura, 2004) was disseminated to participants ($N=28$). This questionnaire measured self-efficacy, outcome expectations, socio-structural factors, goal setting and behaviour. Multiple regressions were analyzed predicting participants' practice of client focused father involvement consulting.

Results

Bivariate correlations demonstrated the anticipated patterns of association between SCT-based constructs. Multiple regression analysis indicated that outcome expectations and barriers were significant predictors of client focused father involvement consulting.

Conclusions

Participants reported that the education increased their self-efficacy, outcome expectations and client focused father involvement consulting behaviour. Future education should be accessible, increase counselling confidence and address beliefs about the outcomes and challenges of father involvement consulting.

Key Words: client centred care, father involvement, breastfeeding, continuing education, Social Cognitive Theory

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List of Abbreviations

CHW	Commune Health Worker
EBF	Exclusive Breastfeeding

Chapter 1: Introduction

Breastfeeding is one of the most important issues in maternal child health today and father involvement is a key component in the support and duration of breastfeeding. Researchers have demonstrated that children who have been exclusively breastfed for a long period of time have higher IQ scores. These IQ scores are highest for those breastfed for greater than six months (Jedrychowski et al., 2012). Children also have better attention, social competence (Julvez et al., 2007) and less chance of having behavioural problems (Heikkila, Sacker, Kelly, Renfrew & Quigley, 2011). Breastfeeding benefits also include reduced risk of respiratory, urinary and gastrointestinal infections, reduced risk of sudden infant death syndrome, childhood onset diabetes, and eczema (Earle, 2000). In addition to the benefits of breastfeeding, there are also many benefits to children when fathers are highly involved. Infants have a higher cognition at six months and 12 months, toddlers are better problem solvers, and children demonstrate higher IQs by three years of age when fathers are highly involved (Allen & Daly, 2007). School aged children of involved fathers also have higher academic performance, higher verbal skill ratings and enjoy school with a more positive attitude (Allen & Daly, 2007). There are many ways in which high levels of father involvement impact a child's emotional health. Infants relate better to strangers and handle stressful situations more maturely when fathers are highly involved (Allen & Daly, 2007). "Father involvement is positively correlated with children's overall life satisfaction and their experience of less depression" (Allen & Daly, 2007, p. 3). Higher emotional stability in children with less anxiety, distress, fear and guilt, is associated with father involvement (Allen & Daly, 2007). Children of involved fathers "demonstrate a greater internal locus

of control” (p. 3), take initiative and show less impulsive behaviour (Allen & Daly, 2007). Father involvement can directly impact breastfeeding success and duration. Allen and Daly (2007) state, “when fathers are emotionally supportive of their spouses, wives are more likely to enjoy a greater sense of well-being, good postpartum mental health, and have a relatively problem free pregnancy, delivery process and nursing experience” (Allen & Daly, 2007, p. 5). However, a lack of focus on educating and involving fathers in breastfeeding decisions has been found to negatively impact breastfeeding choices (Earle, 2000). Healthcare workers therefore need to involve fathers in health promotion campaigns and health education. “Health professionals have a crucial role in communicating positive views on breastfeeding to new parents” (Hannula, Kaunonen & Tarkka, 2008, p. 1133). Professional encouragement and support of breastfeeding are crucial to breastfeeding initiation and duration. However, in order to promote breastfeeding effectively, healthcare workers need “evidence-based breastfeeding education” (p. 1141). Education interventions need to be implemented and evaluated because they are important for provision of proper care and health teaching about breastfeeding (Watkins & Dodgson, 2010). There are, however, very few researchers who have studied the efficacy of breastfeeding education strategies for healthcare workers (Watkins & Dodgson, 2010). The goal of this study was to contribute to the limited but growing body of evidence on education about father involvement. This study is a one group, post-test only, quasi-experimental design with the goal of evaluating the perceptions of healthcare workers about the efficacy of an education strategy related to continuing education about father involvement and breastfeeding counselling. A need was identified in Vietnam for father involvement in breastfeeding (Bich, Hoa & Malqvist,

2013). Since the fathers must be educated on this topic, a further need for education for healthcare workers and evaluation of this education was identified (Bich, Rempel et al., 2013). This study was conducted in Vietnam with Commune Health Workers (CHWs) and midwives who have received father involvement and breastfeeding counselling education. CHWs are the healthcare workers (physicians, physician assistants and nurses) that currently work in the Commune Health Centres throughout Vietnam. This study used the Social Cognitive Theory variables of self-efficacy, outcome expectations, sociostructural factors, and goals (Bandura, 2004) to guide the examination of the efficacy of this education strategy. The following literature review discusses breastfeeding and father involvement and related issues in South-East Asia, the role of healthcare workers in support of breastfeeding, training for healthcare workers, evaluation of education strategies, knowledge change and transfer, and theory content. The research questions and hypotheses are addressed at the end of the literature review which is then followed by a third chapter on the experimental methods. The fourth chapter addresses the data analysis results, and the fifth chapter addresses a discussion and conclusion.

Chapter 2: Literature Review

Search Strategy

To complete a literature review about this important subject, the following databases were searched: Academic OneFile, Academic Search Complete, CINAHL, ERIC, Medline, PsycINFO, Science Citation Index and Social Science Citation Index. In an attempt to use the most current literature, most articles were from the years 2009 and later. Some articles that were older (to the year 2000) were used if they contained very useful information. The topics for which a literature search was conducted were: father involvement in breastfeeding and infant care, breastfeeding, breastfeeding in Vietnam, continuing education about breastfeeding for nurses, continuing education, evaluation of continuing education for nurses, knowledge translation, and Social Cognitive Theory. Databases were searched with a combination of terms including: “breastfeeding benefits”, “father involvement” + “breastfeeding”, “Vietnam” + “breastfeeding”, “breastfeeding” + “father involvement” + “Vietnam”, “healthcare workers” + “breastfeeding”, “nurses” + “breastfeeding” + “continuing education”, “evaluation” + “continuing education” + “healthcare workers”, “evaluation” + “continuing education” + “nurses”, “knowledge translation” + “healthcare workers”, “knowledge translation” + “nursing”, “Social Cognitive Theory”, “Social Cognitive Theory + “education + nursing”.

Breastfeeding and Father Involvement in East Asia

Breastfeeding education and counselling strategies are very important worldwide, and especially in East Asia and Vietnam. Putthakeo, Ali, Ito, Vilayhong, and Kuroiwa (2009) investigated factors affecting breastfeeding in Laos, South-East Asia using a cross-sectional study of semi-structured questionnaires from 400 mothers. The key

conclusions these authors found are important for knowledge related to breastfeeding in this part of Asia. They found that the exclusive breastfeeding to six months rate was only 19.4% and the rate of continued breastfeeding to two years was only 18.6% in this area. They suggested that interventions are needed to help families improve these rates for breastfeeding success. Encouragement from the fathers and adequate spousal communication were found to greatly contribute to breastfeeding rates. Specifically, fathers can play an important role in breastfeeding if they provide encouragement and support to mothers thereby influencing breastfeeding duration. A second area for improvement was identified as the need for decreasing the viewing of formula company commercials which were reported by 45% of mothers as having influence on them to formula feed (Putthakeo et al., 2009).

UNICEF (2006) reported a 43% exclusive breastfeeding rate (in the first six months of life) in East Asia in 2006. In 2012 they issued a press release entitled “UNICEF rings alarm bells as breastfeeding rates plummet in East Asia”. In this statement they call for attention to breastfeeding for survival and cognitive development of children. They also state that increased breastfeeding rates in East Asia will lead to economic development as educational achievement grows and health costs and malnutrition are reduced when a child is breastfed. Vietnam is reported to have an exclusive breastfeeding rate (to six months of age) of less than 20% as of 2012 (UNICEF Press Centre, 2012). One of 6 main objectives of the Vietnam National Plan on Action for Nutrition (Vietnam Ministry of Health, 2012) is to “improve knowledge and practices of proper nutrition” (p. 16). The first indicator of this objective is to increase the exclusive breastfeeding rate (for the first 6 months of life) to 27% by the year 2015. The

goals for attaining this objective are: create mass media campaigns promoting exclusive breastfeeding (EBF), improve the awareness of healthcare workers about EBF practices through workshops and other education strategies, and educate mothers through commune health centres with support groups and counselling (Vietnam Ministry of Health, 2012).

Eriksson et al. (2009) assert that Vietnam has made substantial improvements in child and infant survival, but neonatal mortality rates have not changed in thirty years. Neonatal mortality (birth to 28 days) in Vietnam accounts for nearly 75,000 out of 100,000 infant deaths (up to one year of life). Practice guidelines for reproductive health care were implemented by the Ministry of Public Health in Vietnam in 2003 to try to address this neonatal mortality rate (Erikson et al., 2009). Eriksson et al. studied 412 healthcare workers near Hanoi to discover knowledge levels about neonatal care procedures relevant to the reproductive health care guidelines. The results of this cross-sectional survey indicated that the commune health centres each had at least one midwife or assistant doctor responsible for neonatal care and nurses and doctors were also available. The workers were all questioned on knowledge of issues such as breastfeeding, postpartum care, infection management, low birth weight, and home visits. There was a wide discrepancy between regions; the most knowledgeable workers were found at the commune health centres closest to hospitals and with a higher socioeconomic status, but the overall knowledge base in all regions was considered poor. The areas with the lowest knowledge levels had the highest neonatal mortality rate. Overall, staff showed a greater knowledge base in initiating breastfeeding than sustaining breastfeeding. This indicated a knowledge deficit regarding the World Health Organization's guidelines for

duration of breastfeeding. There was confusion among the health care workers as to when a home visit should be conducted and over half of all patients did not receive a postpartum home visit as recommended in the guidelines; "...the absence of home visits might therefore have severe consequences for families" (Eriksson et al., 2009, p. 8).

Although home visits are not defined well in this article, the idea of the healthcare worker visiting clients at home is presented as an important component of health care support in Vietnam (Eriksson et al., 2009).

Duong, Lee, and Binns (2005) examined breastfeeding practices in Vietnam through a longitudinal study of 463 postpartum women because malnutrition in children under five years of age in Vietnam remained a major health risk, even with 2003 Public Health guidelines. In fact, Vietnam was reported as having one of the highest malnutrition rates in children in South-East Asia, with inappropriate feeding as a major contributing factor (Duong et al., 2005). Inappropriate feeding consists of early introduction of complementary food before six months of age and formula feeding. In this study, only 31% of babies less than two months of age were exclusively breastfed and, after five months of age, there were no babies being exclusively breastfed. Duong et al. discovered factors influencing breastfeeding to include: mothers' employment, perception of not enough milk production, cultural environment, health care workers and marketing of formula. Only 22% of women in this study reported being given information or education about breastfeeding from health care workers and only 7.5% indicated having individual discussions with health care workers related to breastfeeding. Healthcare workers reported having very little education about breastfeeding counselling even with the new guidelines in place. The workers lacked knowledge and skills to

provide breastfeeding counselling and were not confident in this role (Duong et al., 2005). The commercial push of infant formula labeled as “complementary food” has damaged the public’s knowledge and belief of exclusive breastfeeding (Duong, 2005). Ninety-eight percent of women in Duong et al.’s (2005) study reported being exposed to formula advertisements. Duong et al. stated, “To maintain [exclusive breastfeeding] practice, women seem to need more motivation from health workers. However, health workers seem to lack the necessary knowledge and skills for practical counselling” (p. 342).

McLaughlin and Forster (2006) performed a qualitative study examining initial breastfeeding practices and attitudes of 100 Vietnamese-born women, as well as the same number of women from Turkey and Australia. Structured questionnaires were completed by the women between 24 hours postpartum and discharge from hospital. The data from the Vietnamese women indicated the lowest breastfeeding initiation rates (75%) and the lowest exclusive breastfeeding rates (60%), as well as the highest incidence of formula given to babies (40%). Only 79% of the Vietnamese women planned to breastfeed (compared to 90% of Australian women) and the Vietnamese women did not think that colostrum was a needed ingredient for their babies. In fact, traditional Vietnamese culture discards colostrum and so breastfeeding is not started until day 3 of life even with health education supporting exclusive breastfeeding from the beginning (McLaughlin & Forster, 2006). The Vietnamese women in this study also reported more often that their partners had negative feelings towards breastfeeding (McLaughlin & Forster, 2006). Although this study is primarily examining immigrant women in Australia, the cultural issues of the Vietnamese beliefs are pertinent to women living in Vietnam. This

reinforces the need for breastfeeding education for families to increase the exclusive breastfeeding rates in Vietnam.

Other countries are also seeking ways to improve breastfeeding rates and are considering the possible role of the father as a way to change breastfeeding behaviours. In Finland, fathers were found to be the most important support person to a mother in relationship to breastfeeding success and competence (Tarkka, 2001). Conversely, Ito, Fujiwara and Barr (2013) performed a quantitative study in Japan about the role of father involvement in child care related to exclusive breastfeeding rates and obtained results that contradicted their hypothesis that father involvement would positively impact exclusive breastfeeding rates. They discovered that father involvement in childcare was more likely to promote formula feeding. Ito et al. therefore suggested a great need for education programs for fathers on how father involvement can support and promote breastfeeding. They also stated the need for intervention studies assessing the effect of father involvement and breastfeeding education on breastfeeding rates. These are highly important suggestions for East Asia but also for breastfeeding success worldwide. Based on these articles, it is very important to discover how to support families in order to improve breastfeeding rates and duration. It is suggested that this should take the form of support for the whole family, not just support for the mother. As stated by de Montigny, Lacharite, and Devault (2012), “although fathers are noted by authors across the world as important factors across the world in mothers’ decisions to initiate and pursue breastfeeding, they have only rarely been investigated as key players in the experience” (p. 12). Earle (2000) sought to explore reasons why women do not breastfeed. One of the things she found is that there is not enough focus on the fathers in breastfeeding

decisions and this can negatively impact breastfeeding choices. Therefore healthcare workers should involve men in health promotion campaigns and health education related to breastfeeding. How to do this effectively is a knowledge gap for health professionals.

Bich, Hoa and Malqvist (2013) studied breastfeeding and father involvement in Vietnam. The authors designed and implemented a quasi-experimental study with an intervention group and a control group. The intervention group was comprised of 239 couples. The fathers in this group received prenatal and postnatal instruction on involvement in breastfeeding, counselling at commune health centres, and home visits. The control group of 230 couples received no education on father involvement in breastfeeding. At four months postpartum, there was a significant difference in breastfeeding rates between those in the intervention and control group. These authors found that education of fathers in the antenatal and postpartum periods positively affected breastfeeding initiation and duration. They acknowledge that in low and middle-income countries such as Vietnam, the role of fathers in breastfeeding is not well recognized or tested. This is a research gap that should therefore be addressed to support the initiation and duration of exclusive breastfeeding. The study currently being conducted in Vietnam by Bich, Rempel, Rempel, and Hoa (2013) will help to address this research gap. Their study aims to examine the results of a father involvement intervention to improve exclusive breastfeeding rates and infant development in Vietnam. Similar to the study by Bich et al. (2013), this study will compare results of an intervention and control group. The intervention group includes fathers who are receiving prenatal and postnatal father involvement counselling by commune health workers while the control group is not receiving this counselling. The study includes the training for healthcare workers that

will be evaluated in the research study which this present paper addresses. Details regarding the healthcare worker training are discussed in chapter 3.

The Role of Healthcare Workers

To prepare for an evaluation of healthcare worker training, a literature review was conducted to determine if, and how, healthcare workers impact breastfeeding initiation and duration and positively impact father involvement. The authors of one study reported that the determining factor for breastfeeding success was education by the public health nurse (Tarkka, 2001). Other studies demonstrate the impact of healthcare worker practice related to breastfeeding on breastfeeding rates, with both physician and nursing support being important (Mellin, Poplawski, Gole, & Mass, 2011). Healthcare workers also impact breastfeeding success by communicating positive views regarding breastfeeding to parents (Hannula, Kaunonen & Tarkka, 2008). Through a systematic review of literature, Hannula et al. (2008) also found that professional encouragement and support of breastfeeding was crucial to breastfeeding initiation and duration, as women were more likely to breastfeed with this support. The authors further acknowledged that in order to promote breastfeeding effectively, healthcare workers first need “evidence-based breastfeeding education” (p. 1141). Promotion strategies by healthcare workers spanning from pregnancy through infancy were found by these authors to be more effective than interventions at one time point (Hannula, et al., 2008).

The impact on father involvement by healthcare workers could be significant to breastfeeding rates and duration. Wolfberg et al. (2004) performed a randomized controlled trial of educational sessions for fathers related to breastfeeding because these authors recognized that fathers impact breastfeeding decisions. The authors stated that no

research had been previously done to test interventions for fathers on this topic and that this was a major research gap. Wolfberg et al. planned an intervention teaching session for fathers that included discussion, sharing of thoughts related to breastfeeding, videos, slides, and role-play. The sessions were conducted in small groups every two weeks during the third trimester and maintained an informal environment with non-didactic teaching and support. Teachers were fathers themselves and of the same ethnicity as the participants. The main messages for the fathers were about the benefits of breastmilk and communication with their partners. The fathers were also taught to disregard common misconceptions such as: breastfeeding distances a father from his child, breastfeeding impairs a couple's romantic relationship and breastfeeding ruins a woman's breasts. Advocating for breastfeeding was taught and peer support encouraged. The control group sessions for this study focused on fathers being educated on infant care only. The results from this study show that when the fathers attended the intervention group, mothers were more likely to initiate breastfeeding but the duration of breastfeeding was not significantly different from the control group. These authors encouraged further development of education for fathers about breastfeeding and testing of that education (Wolfberg et al., 2004).

Another randomized clinical trial to evaluate a father involvement program was performed in California to address a scarcity of evaluation for father involvement interventions. Although there is interest in father involvement interventions, there had been almost no evaluations of the interventions to determine efficacy (Pruett, Cowan, Cowan, & Pruett, 2009). The authors evaluated communication, training, staffing, retention, content of the intervention and cultural considerations. The intervention

consisted of 16 weekly sessions for fathers at community centres. At these sessions, the fathers participated in group discussion, activities, presentations and problem solving related to father involvement. Through this trial, the authors found that successful programs had staff members that were trained to work specifically with men and who took into account men's various work schedules and other demands. They also found that staff needed to be highly trained in order to provide accurate counselling about father involvement. Training was supported with orientation sessions, meetings, curriculum education, team coordination, and education about clinical problems that may arise. The authors found better retention of fathers to the study when the staff worked cohesively. They reiterated the need for highly trained staff due to the nature of needed skills to counsel individuals, families and groups (Pruett et al., 2009).

Training for Healthcare Workers

As Pruett et al. (2009) suggest, healthcare workers will need to be educated about father involvement and support of breastfeeding if they are to have impact on this important behaviour. A literature search seeking information about training of healthcare workers specifically related to father involvement in breastfeeding was unsuccessful. Because breastfeeding education of mothers is a related topic, literature related to healthcare worker training about breastfeeding in a more general sense was examined to determine recommendations which would be valuable for healthcare worker training for providing father involvement education. The information found discusses content, methodology and style, as well as skill building. Content and methodology as well as values are integral to any training method for healthcare workers (Wiggins et al., 2013). Teachers must value the experience of the healthcare workers, including their life-views

and traditions. Content of teaching sessions should include skill development such as identification of community need, communication skills, counselling skills, community building skills, leadership and advocacy, service coordination and teaching skills. Content should also include orientation to each specific role of the education team, working with a multidisciplinary team and health promotion issues. These are ideas that are very important when creating a teaching plan for father involvement in breastfeeding. The healthcare workers will benefit if all of these skills are reviewed. This will in turn impact the fathers and families being supported by the healthcare workers.

An article by Allery (2009) offers advice for teaching practical skills in the health care setting. This is an educational article for teachers about methods for teaching these skills. This author uses a skills hierarchy and task analysis to show the movement from novice through mastery. She states that to accomplish mastery, students need conceptualization (knowing where a skill can be used and why it is important), visualization (being able to see the skill), verbalization (being able to talk about the skill), physical practice (being able to do the skill) and correction and reinforcement (receiving feedback). Allery (2009) acknowledges some impediments to mastery such as inadequate teaching, previous beliefs about a task that are incorrect, anxiety, and inaccurate perception of their performance. The author further suggests that teachers establish components of the skill and then divide it into steps to be taught. This is relevant to health care workers world-wide and to a variety of healthcare topics. Based on this idea, health care workers learning about father involvement in breastfeeding need to progress through training to a level of mastery in order to impact clients effectively. Therefore, the father involvement education for healthcare workers is the key component

in the mastery of the skill of client focused father involvement consulting.

Buskens and Jaffe (2008) also found the need for mastery of counselling skills in healthcare workers. These authors studied counselling practices in health care workers working with breastfeeding mothers in communities in Southern Africa on the topic of HIV transmission through ethnographic research over 7 months. They found many observed counselling sessions to be “demotivating” as mothers said they felt judged. The authors explain they found a divide between health care workers and mothers because each party had different agendas and needs. The authors state the counselling sessions were supposed to be client-centred and non-directive but in reality the authors found the sessions to be informative and directive in style. Healthcare workers described feeling that the mothers were not compliant and so they felt the need to be confrontational. The healthcare workers also described feeling depressed, stressed and burnt out (Buskens & Jaffe, 2008). Based on these observations, the authors posed recommendations for improvement needed in education such as: counsellors need to be provided with the tools to manage and acknowledge the different agendas of clients and counsellors, counsellors need to be sensitized to the behaviour change needed in clients, and education needs to be provided in guiding conversations and motivating and empowering clients (Buskens & Jaffe, 2008). These are important observations for any healthcare worker learning counselling styles to teach about breastfeeding. Similarly, healthcare workers will be more likely to motivate father involvement in breastfeeding if they use non-directive, client-focused counselling methods.

Ward and Byrne (2011) have made many suggestions for breastfeeding continuing education based on a systematic review of literature. They reviewed fifteen

studies from nine countries. Their article is based on the premise that support by trained healthcare professionals increases the duration of breastfeeding while lack of support, knowledge or the receipt of inconsistent advice leads to reduced initiation and duration of breastfeeding (Ward & Byrne, 2011). These authors state that less than 50% of nurses who usually provide breastfeeding advice to families receive breastfeeding education during school or in a continuing education setting. The nurses without breastfeeding education tend to rely on experience and opinions of others rather than research which leads to a “severe knowledge deficit” (p. 381). Ward and Byrne (2011) evaluated the literature for the following items: knowledge and attitudes of healthcare workers, BFHI (Breastfeeding Friendly Hospital Initiative) compliance, clinical skills and practices, counselling and support behaviour, and breastfeeding outcomes, length of intervention, resistance to change and sustainability of change. The results showed that knowledge and attitude about breastfeeding increased in almost all of the studies after the training course and BFHI compliance increased. Breastfeeding clinical skills and confidence also increased after education but not all clinical practices were changed. Counselling skills were improved and healthcare workers more often provided supportive rather than directive counselling to families after an education session. Many of the studies reviewed in this article were reported by their authors to show an increase in either breastfeeding rate, duration or both after healthcare workers had received training. The studies in which these changes were reported all involved training courses that were over eighteen hours in length. Lack of support from the institutions and resistance to change were seen to affect results. One author found that resulting change wore off over time but most found that effects could be sustainable. None of the studies demonstrated an

improvement in initiation of breastfeeding. These authors recommend that research be done on successful breastfeeding education for families within the antenatal period (Ward & Byrne, 2011).

As well as education on breastfeeding, healthcare workers also need clarification about the difference between supporting families and just giving advice about breastfeeding (Abbott, Renfrew & McFadden, 2006). In their qualitative study using semi-structured interviews with key informants (midwives, health visitors and infant feeding advisors), these authors evaluated breastfeeding education in the community that was not a part of a formal college program. Abbott et al. found that support and advice were confused. They also found that successful breastfeeding education of health care workers included the healthcare workers debriefing about their own experiences or thoughts surrounding breastfeeding. They suggest the debriefing should address issues that may hinder the current learning experience such as negative personal experiences with breastfeeding (Abbott et al., 2006). Watkins and Dodgson (2010) state that healthcare professionals often do not have the education required to provide competent breastfeeding care so they believe and teach misinformation. These authors posit that there are very few researchers who have studied the efficacy of breastfeeding continuing education strategies but that these education sessions are important to provide proper care and health teaching. Based on a literature review of fifteen articles from eight different countries reporting studies regarding breastfeeding education sessions for healthcare workers, these authors found many results. Breastfeeding knowledge of healthcare workers was associated with confidence and/or attitude change of these healthcare workers. Breastfeeding rates declined after discharge from hospital, leading

researchers to suggest ongoing care for families as essential to breastfeeding success.

Support that included prenatal and postnatal breastfeeding support was found to be most effective (Watkins & Dodgson, 2010).

Evaluation of Training for Healthcare Workers

Based on the literature presented, it appears that evaluation of the teaching strategies used for healthcare workers is key to the success of a program. Evaluation strategies need to be addressed and utilized and one of the key elements to assess is the perception of healthcare workers about the education. A definition of evaluation is “the process of determining the value or worth of a health promotion program or any of its components” (McKenzie, Neiger, & Thackeray, 2013, p. 373). Evaluation should include “the degree to which the program influenced knowledge, attitudes, confidence, abilities and behaviours” (p. 376). Evaluation can be divided into two main components. The first is that of formative evaluation which is the assessment and improvement of the program that can be utilized throughout the teaching strategy (King, 2005). This type of evaluation allows the teachers to see the learners’ ongoing needs, progress, and response to the teaching in order to adapt the strategy as needed (King, 2005). The second type of evaluation is summative evaluation which relates to deciding the effectiveness of a program at its conclusion. The benefit of this type of evaluation is that it provides an overview of the program and the learner’s progress after the teaching strategy (King, 2005). This current study could be argued to incorporate both types of evaluation. It provided formative evaluation by suggesting improvements to the teaching strategy by examining its processes (Jason, 2008) and it provided summative evaluation by judging the success of the strategy based on behaviour outcomes (Jason, 2008).

Some potential barriers in evaluation that are particularly relevant for healthcare worker training are the issues of cultural sensitivity and the degree of change. If a program cannot be delivered in a way that is culturally appropriate it may not be successful. Also, if a change is small or comes slowly then evaluation may be difficult to conduct (McKenzie et al., 2013). Frye and Hemmer (2012) define educational program evaluation as “systematic collection and analysis of information related to the design, implementation, and outcomes of a program, for the purpose of monitoring and improving the quality and effectiveness of the program” (p. 289). Based on this definition these authors state that evaluation needs to discover what makes a program a success and then address issues found through the evaluation process. The authors suggest that “the model used to define the evaluation process” decides how the evaluation will be conducted and utilized (p. 289). Learning about healthcare workers’ perceptions of the training is an excellent start to provide insight about why a program might or might not have been successful. Wiggins et al. (2013) suggest that evaluation be measured by objective assessment of skill and knowledge change and also by perception regarding impact of the training. Knowledge change and transfer could be an excellent indicator for this evaluation.

Assessing Knowledge Change and Transfer

“Educational programs are fundamentally about change; program evaluation should be designed to determine whether change has occurred” (Frye & Hemmer, 2013, p. 288). Change in healthcare worker practice related to father involvement in breastfeeding is an example of knowledge change and transfer. Following the education of CHWs and midwives about father involvement (Bich, Rempel, et al., 2013), the

desired outcome is that CHWs and midwives will practice client focused father involvement consulting. For the purposes of this study, this term is defined as non-directive counselling that focuses on the fathers' needs, encourages the fathers to give their own ideas, and enables the fathers to make their own informed decisions about involvement in breastfeeding and in having a relationship with their infants. Because "intervention studies in the knowledge translation field are particularly required in developing countries" (Edwards & Roelofs, 2006, p. 45), it is important to assess knowledge change and transfer in the Vietnam father involvement study to determine education program success. So how do we determine if change in healthcare worker trainees has occurred in the trainees? How do the trainees then transfer that knowledge and practice change to impact their clients?

There are many different ways to address change. For example, Lewin's change theory is used in nursing practice, education, administration and research (Shirey, 2013). The stages of this theory are unfreezing, moving/transitioning, and refreezing. Unfreezing involves identifying the need for change and planning strategies for the change. Transitioning or moving is "the inner movement that individuals make in reaction to change" and requires a plan for change as well as engaging people to try out the change (p. 70). The third stage of refreezing involves incorporating the change into current practice so it becomes the norm (Shirey, 2013). Graham defined knowledge transfer as, "a dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge" (Tetroe, 2007, p.1). Graham's model (see Figure 1) involves identifying the problem, adapting knowledge to local context, assessing barriers to knowledge use, selecting and implementing interventions,

monitoring knowledge use, evaluating outcomes and sustaining knowledge use (Tetroe, 2007). The model has two main stages of knowledge creation and action (Sudsawad, 2007). Knowledge creation is represented in the model as a funnel. The funnel depicts the major types of research used in health care: knowledge inquiry, knowledge synthesis and knowledge products or tools. This part of the model is depicted as a funnel because the information is filtered for use and becomes more practical the further into the funnel. So that the correct information is being disseminated, the five questions that need to be asked are: What should be disseminated, who should disseminate it, how should it be disseminated and with what effect (Graham et al., 2006). As Graham et al. (2006) stated, the action cycle of the model is the procedure or steps that might need to be taken in order for the knowledge to be utilized. The goal of these steps is to produce planned or deliberate change. These steps are dynamic and include: identifying a problem and the knowledge relevant to correcting it, planning an intervention and evaluating the outcomes and sustainability (see Figure 1).

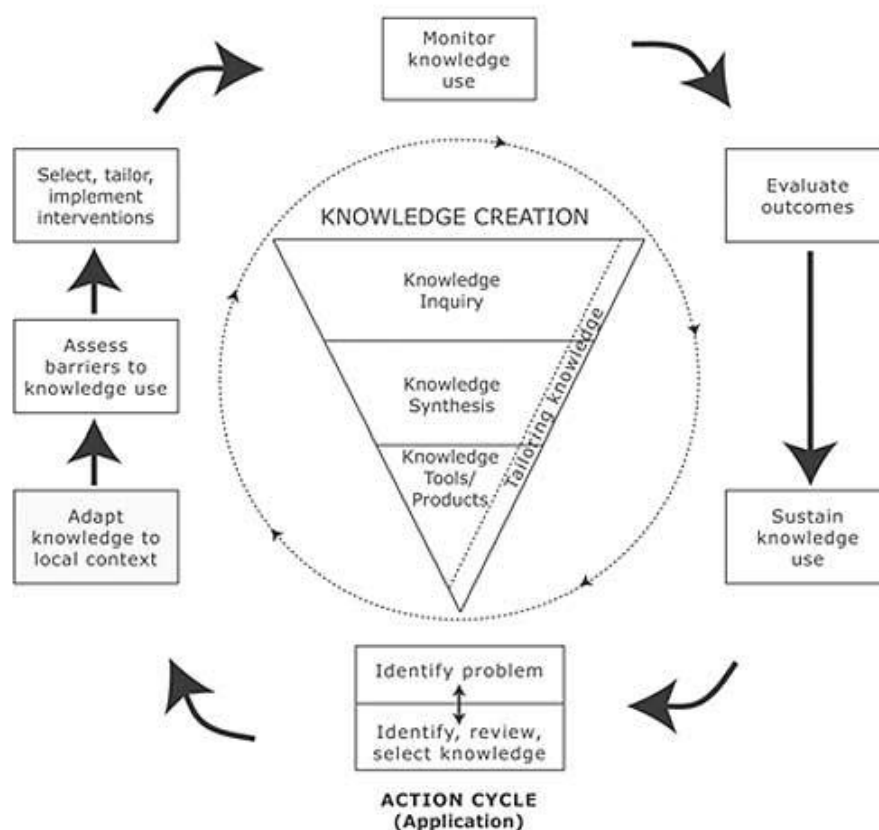


Figure 1. Graham's knowledge to action process framework (Sudsawad, 2007).

Tetroe (2007) stated that the first step to implementing change in knowledge is first having all the participants agree on the need for change. In father involvement education, this needs to include education as to the importance of the topic so healthcare workers understand the need for change. Tetroe acknowledged that evaluating change could be done in numerous time points in parts of the cycle of Graham's model and suggested that some tools for measuring knowledge translation are reports, case-studies, interviews, surveys, and document analysis. There could be many more indicators of knowledge change. For example, trainee confidence increase is a good indicator of adequate knowledge change and translation (King, O'Brien, Edelman, & Fazio, 2011). During a

study of health care workers surrounding a two-day training seminar, King et al. posed the question, “how confident are you that you will be able to implement this training program back in your community?” (p. 383). These authors hypothesized that, following the training session, the healthcare workers would have an increased knowledge base and improved attitude with regards to the training material. They also hypothesized that the higher the confidence level, the greater the knowledge base but did not find this last hypothesis to be true and in fact suggest that using a scale for confidence with only four points was an issue. These authors suggest using at least a five-point scale (King et al., 2011).

Wiley, Irwin and Morrow (2012) performed a qualitative study with ten healthcare workers following a training session on interview skills and promoting patient behaviour change to determine practitioners’ perceptions of the intervention. Perceptions about confidence, competence and attitudes were examined pre-intervention and at 1 and 4 weeks post-intervention using in depth interviews. Prior to the training session intervention, the healthcare workers reported feelings of frustration with the ability to promote behaviour change but they also felt persistence was important in continuing to try this promotion. They felt that giving advice was key to promoting behaviour change but that they needed more tools and support. They reported feeling low confidence and competency levels, and low rapport with clients. Finally they felt that promoting behaviour change was very hard work. Following the teaching session, which included interactive discussion, demonstration, skill practice and feedback, the health care workers reported renewed feelings of motivation in their role. They decreased the amount of advice-giving and worked with patients to plan care. They also perceived a positive

impact on clients and felt that the role was much less work. The practitioners were happy with the teaching and the received tools and felt much more confident and competent in their role (Wiley, et al., 2012).

Another area for assessment of change in knowledge and knowledge transfer is the issue of empowerment. Empowerment practices can encourage employees to “seek out new and better ways of doing things” (Fernandez & Moldogaziev, 2012, p. 155). There are two different perspectives on empowerment. The first is managerial empowerment where the organization leaders share power with employees through joint decision-making and knowledge (Fernandez & Moldogaziev, 2012). The second is psychological empowerment which creates self-efficacy and task motivation to make tasks valuable and meaningful while promoting choice and competence. Psychological empowerment leads to greater self-expectancy in task performance, greater effort and persistence to perform the task, and a greater sense of autonomy (Fernandez & Moldogaziev, 2012).

A further important component in the knowledge translation process is sustainability, as mentioned in Graham’s model above. Edwards and Roelofs (2006) have written an article about sustainability in international health projects. They posit that “unforeseen circumstances may threaten the initial uptake of innovative project design elements” and that “sustaining the long-term benefits of successful interventions involves change at individual, organizational, and institutional levels” (p. 45). A major threat to sustainability is listed as lack of support for training. The training Edward and Roelofs’ group provided was for maternal and child health workers in ten rural counties in China. The training consisted of topics and skills related to maternal child health and

relationship building with clients. The training was considered a success (trainees described high levels of knowledge change) until the health care workers returned to their communities with not enough support to sustain the knowledge from the training.

Questions to consider that would aid sustainability are listed by these authors as: What structures need to be in place to support trainees implementation of new learning or projects? How will sustainability be managed? Do existing policies support uptake of new knowledge/projects? How can new projects be adapted as needed? These questions emphasize the need for assessing local support and policy as well as healthcare workers perceptions of planned support.

As demonstrated by the literature, it is important to assess knowledge change and transfer to determine education program success. A theory is needed to guide examination of healthcare workers perceptions of knowledge change and transfer (Frye & Hemmer, 2012). The Social Cognitive Theory may be useful in examining healthcare workers' perceptions of knowledge and practice after a teaching intervention.

Social Cognitive Theory

The Social Cognitive Theory (SCT) by Bandura is described as an interaction of behaviour, personal factors and environmental factors (Hayden, 2014). Personal factors include a person's ability to "symbolize behaviour, to anticipate the outcomes of behaviour, to learn by observing others, to have confidence in performing a behaviour (including overcoming the problems in performing the behaviour), to self-determine or self-regulate behaviour and to reflect on and analyze experience" (Baranowski, Perry, & Parcel, 2002, p. 165). Health educators use this theory to develop techniques and procedures as well as interventions for teaching (Baranowkil et al., 2002). For example,

in her article addressing teaching styles in nursing professional development, Curran (2014) posits that nurses must be lifelong learners and one common theme for nursing education is the Social Cognitive Theory. The four concepts of Bandura's theory that facilitate learning collectively are observation, self-regulation, self-efficacy and reciprocal determinism. With these four constructs to guide the learning experience, the learned behaviour will become incorporated into practice (Curran, 2014). The key concepts of SCT are organized into five categories: psychological determinants of behaviour, observational learning, environmental determinants of behaviour, self-regulation and moral disengagement. Psychological determinants of behaviour include reciprocal determinism, outcome expectations, and self-efficacy. Environmental determinants of behaviour include motivation, facilitators and barriers (McAlister, Perry & Parcel, 2008). The constructs of this theory can be important in understanding the effect of knowledge change and transfer in healthcare workers' learning about father involvement in order to promote practice change.

The pathways model by Bandura (2004) has been chosen for this study (see Figure 2). This model does not demonstrate all of the possible constructs of the SCT but may be useful for the purposes of learning perceptions of CHWs about the effect of the teaching strategy to implement client focused father involvement consulting. There are many ways in which this pathway is applicable to this study. For example, in the discussion of this pathway model, Bandura (2004) stated that through this model we can see the "optimal ways of translating" (p. 144) knowledge into practice, which is a key component of education for healthcare workers. Also, the role of self-efficacy in this pathway is important to learning because self-efficacy in nursing has been shown to

impact learning, professional behaviour and competence (Chang & Crowe, 2011).

Another example is that in adult learning the intended focus of an education strategy is a change in behaviour, skills, values and beliefs (Caffarella & Daffron, 2013) which directly relates to Bandura's path to behaviour change. The behaviour, or practice, that this education session attempted to change, and which we are now examining, is that of client focused father involvement consulting after the education strategy.

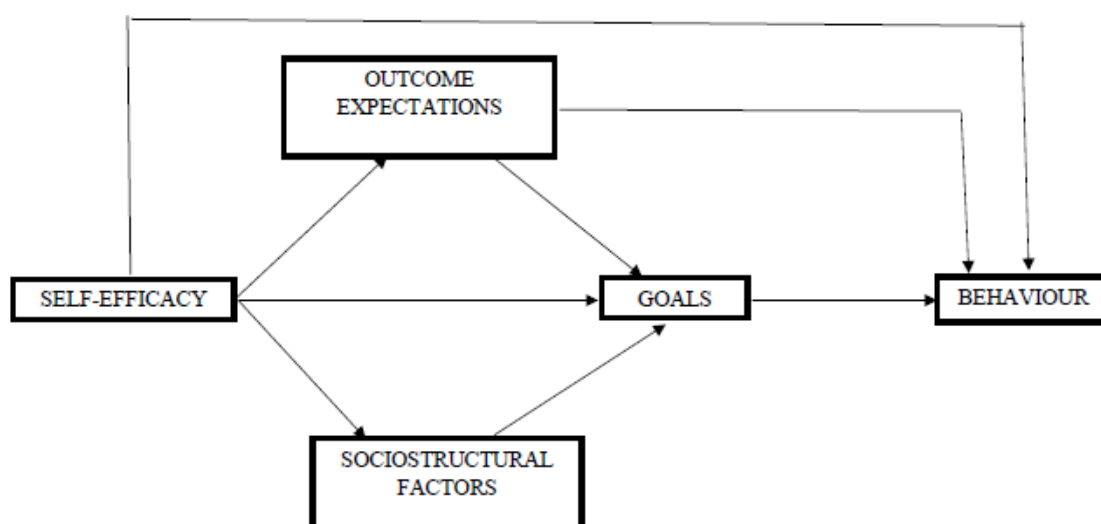


Figure 2. Bandura's structural paths of influence (Bandura, 2004).

Reciprocal determinism. Reciprocal determinism is defined by Baranowski et al. (2002) as the relationship or interaction between the person, behaviour and environment. This is considered a dynamic relationship. Reciprocal determinism is important to healthcare workers as this construct takes into account the dynamic relationships of influence. The environment, the person and the behaviour of the person all interplay to influence behaviour change (Baranowski et al., 2002). Healthcare workers' personal

characteristics, environment and past behaviour all impact the care that is given to clients. These three aspects also influence how the healthcare workers learn and how they transfer the new knowledge. The environment can include the social environment of the healthcare worker and also that of the client and the client's home or family. This can also include social supports and support of the agency (Baranowski et al., 2002). Although not directly shown on the pathways model (see Figure 2), reciprocal determinism can be an important concept to demonstrate the dynamic interaction of the constructs.

Outcome expectations and self-efficacy. Outcome expectations are the anticipated and believed outcome of the behaviour while self-efficacy is defined as “the person's confidence in performing a particular behaviour and in overcoming barriers to that behaviour” (Baranowski et al., 2002, p. 169). Self-efficacy is believed by Bandura (2004) to be the most important determinant within this theory because it directly affects behaviour change and also indirectly affects behaviour change through its effect on the other constructs such as goal setting, motivation, outcome expectations, facilitators and barriers. Knowledge of the skill or behaviour and how to perform it is a key component of self-efficacy. Knowledge comes before capability to perform a new task (Hayden, 2014) and is listed by Bandura (2004) as a precondition for behaviour change. The education program about father involvement in breastfeeding for health care workers addresses knowledge deficits to promote behaviour or practice change. Knowledge creates the initial condition for change but personal factors are needed to overcome the many barriers to this change. These factors are the constructs of SCT (Bandura, 2000) as shown in Figure 2.

Knowledge and skill must be reinforced by self-efficacy in order for behaviour change to occur (Hayden, 2014). Self-efficacy beliefs impact beliefs about the outcome one expects through the behaviour change (Bandura, 2000). Bandura's self-efficacy and outcome expectations have an effect on evidence based practice. Barriers to evidence based practice include lack of self-confidence in implementing new practice and lack of confidence that this practice will actually improve outcomes (Chang & Crowe, 2011). Self-efficacy in nursing has been shown to impact learning, professional behaviour and competence (Chang & Crowe, 2011). In order for a healthcare worker to improve their practice, they must first believe that this change will cause a positive outcome for themselves or their patients. Generally a healthcare worker with high self-efficacy beliefs will also have high outcome expectations beliefs (Chang & Crowe, 2011).

Outcome expectations are divided into three categories: physical, social and self-evaluative; these also are predictors of behaviour change (Bandura, 2004). Physical outcomes include losses and benefits of performing the behaviour and pleasure of adverse feelings associated with the behaviour change. Social outcomes include the reactions of one's social network to the behaviour change. Self-evaluative outcomes are the ways in which a person feels satisfied or feels a sense of self-worth when changing behaviour. Motivation and self-regulation are involved in this aspect of this expectation (Bandura, 2004). Bandura also states that the strength of a person's belief in their power to produce an effect will determine how long a person will persevere in the behaviour if faced with obstacles. The stronger the perceived self-efficacy, the more likely an individual will sustain the behaviour or practice change (Bandura, 2000). However, self-efficacy has been found to decrease over time, which is why sustainability is an important aspect of

knowledge change. A study by Cohen, Cragin, Wong, and Walker (2012) assessing self-efficacy in midwives and nurses before and after simulation training about obstetrical emergencies found that pre-training self-efficacy results were lowest while the highest levels were immediately after return to communities after the training sessions. Four months following the training showed a slight decrease in self-efficacy levels. It is suggested that barriers such as lack of support for new training in their home sites was a key factor in the decrease in self-efficacy over four months (Cohen et al., 2012).

Sociostructural factors. Facilitators and barriers to behaviour or practice change are important to address. Self-efficacy beliefs directly impact the ability to persevere through obstacles (Bandura, 2000). Bandura lists one type of barrier as personal, such as fatigue or lack of interest in the behaviour. Social or economic barriers are also important factors for the lack of success in behaviour change. Lack of resources or lack of support negatively impact behaviour change (Bandura, 2000). Stress related to behaviour change is also an important barrier to address. Stress reactions are reduced when self-efficacy is reinforced (Bandura, 2000). Penz et al. (2007) performed a study assessing perceived barriers for rural nurses in Canada to receive continuing education. The authors found that major barriers were isolation, time and finances. In their literature review they found that nurses worldwide, both rural and urban, face similar barriers to continuing education including finances, lack of institution support, time, scheduling and family responsibilities. Schweitzer and Krassa (2010) found that barriers to continuing education in nursing were: cost, time, childcare and home responsibilities, peer opinions and attitudes, lack of quality programs, distance to education session, and having other

priorities or commitments. Barriers must, therefore, be addressed to assist healthcare workers with learning and behaviour change.

Self-regulation and goal setting. Any change in practice or behaviour requires self-regulation (Hayden, 2014). Self-regulation is defined as “controlling oneself through self-monitoring, goal-setting, feedback, self-reward, self-instruction, and enlistment of social support” (McAlister et al., 2008, p. 171). Self-regulation is a combination of self-efficacy, outcome expectations and goal setting to produce behaviour change (Hayden, 2014). According to Bandura, people must have “the capability for exercising influence over their own motivation and behaviour (Bandura, 2000, p. 313). In order to accomplish this, an individual must be aware of their performance, conditions and effects produced through self-monitoring. Goal setting is an important part of self-regulation as this comes through assessing one’s self and determining the change needed (Bandura, 2000). Goals are described as distal or proximal with intentions being proximal goals (Bandura, 2004). This links very well with healthcare worker reflective practice. Healthcare workers must assess and evaluate their performance and outcomes for themselves and their clients and then set goals for needed change. This can begin to occur when healthcare workers learn new skills or are taught new information. Self-efficacy, outcome expectations and sociostructural factors, such as barriers and facilitators, affect goal setting, which in turn is a predictor of the behaviour (Bandura, 2004). Healthcare workers must feel that they can accomplish the behaviour in order to have the motivation to accomplish the change (Bandura, 2000).

Relationship to Graham’s knowledge to action process framework. The Social Cognitive Theory is useful in examining healthcare workers’ perceptions of

knowledge and practice after a teaching intervention. This relates to Graham's Knowledge to Action Process Framework as discussed above. The constructs of the SCT are important to discuss within the context of the Knowledge to Action process for training sessions for healthcare workers about fathers role in breastfeeding.

A need was identified in Vietnam for father involvement in breastfeeding. Since the fathers must be educated on this topic, a further need for education for healthcare workers was identified. Knowledge was collected and adapted to local context for training session interventions for the healthcare workers. Some barriers were addressed in this planning. The education consisted of a two-day training seminar for healthcare workers, an observed counselling session with a pilot father, and a reflective interview about this counselling session. The healthcare worker education sessions were completed in April 2014 and training with pilot fathers was done in May, June, July, August and September. The questionnaire for this CHW study was completed in April 2015. This allowed the participants seven months of practicing father involvement consulting following the pilot father sessions before completing the questionnaire. The training seminar included presentations on breastfeeding benefits and skills, counselling skills, father involvement principles, and infant development. It also included discussion and practice counselling with volunteer fathers. Following the teaching sessions, each healthcare worker was expected to be observed providing counselling for a father in the pilot group. A reflective interview with the healthcare worker and a member of the research team then took place. In order to continue to effectively implement training for healthcare workers about father involvement in breastfeeding, it is important to evaluate

the healthcare worker training. Thus, this study was conducted to determine healthcare workers' perceptions of this education process.

The research questions were the following:

1. Following the father involvement education, how do CHWs perceive their ability to provide client focused father involvement consulting?
2. What are the relationships, and the strength of the relationships, between the SCT variables (Bandura, 2004) and CHW reported provision of client focused father involvement consulting following the father involvement education?

Examining the SCT pathways in this context is very important. In order to plan an effective teaching intervention for healthcare workers, the area of focus to best promote client focused father involvement consulting must be determined. Based on Bandura's (2004) pathways, it is most important to have an intervention that mainly increases self-efficacy, but also outcome expectations and goal setting. If this is true, and if the pathways are determined to be significant, the education that impacts these areas will be effective. This could include education with modeling, practice, self-reflection and also education that promotes intrinsic motivation and self-directed learning. These are important concepts for nursing educators. Education based on significant pathways will directly impact teaching focus in the future.

In this study, the paths that were examined to predict behaviour were consistent with the SCT pathway (see Figure 2). Also examined was an adapted SCT pathway including self-efficacy, outcome expectations and sociostructural factors (barriers and facilitators) predicting behaviour. In this adapted pathway, outcome expectations and sociostructural factors were direct predictors of behaviour as opposed to indirectly

affecting behaviour through goal setting. This was a cross-sectional study, so the goal setting questions asked about future goals and the behaviour questions addressed present behaviour. It would have been difficult for the participants to report on their past goals or their future behaviours. Thus, although theoretically consistent, it is temporally illogical for future goals to predict current behaviour, which resulted in the adapted pathway. The original pathway was examined first to determine if the theoretical relationship between goals and behaviour was consistent with the original model.

Based on the review of the literature and the Social Cognitive Theory pathways (Bandura, 2004), the hypotheses for this research project were:

1. Self-efficacy will be correlated with outcome expectations and sociostructural factors (barriers and facilitators).
2. Self-efficacy, outcome expectations and sociostructural factors (barriers and facilitators) will predict goal setting.
3. Self-efficacy, outcome expectations and goal setting will be predictors of CHW behaviour of client focused father involvement consulting.
4. Self-efficacy, outcome expectations and sociostructural factors (barriers and facilitators) will be predictors of CHW behaviour of client focused father involvement consulting.

Chapter 3: Methods

Background

My research study is associated with a larger study headed by my supervisor, Dr. Lynn Rempel and her colleague Dr. Tran Bich from the Hanoi School of Public Health in Vietnam titled, “Fathers Involvement: Saving Brains in Vietnam” (Bich, Rempel, Rempel & Hoa, 2013). This study proposed to increase father involvement to improve exclusive breastfeeding rates and duration and to improve infant development.

The intervention was conducted in 13 communes in one district of Hai Duong province in Vietnam from May 2014 to January 2015. There were approximately 400 fathers in the intervention group who were receiving prenatal and postnatal breastfeeding, father-infant relationship education and supportive counselling from commune health workers (CHWs). This included a prenatal group session, a prenatal home visit, and home visits at 7 days, 6 weeks and 3.5 months post birth. In addition, midwives at the district hospital provided a session with the fathers within the first two days postpartum. The CHWs currently work at Commune Health Centres in the Hai Duong region in Vietnam; providing the counselling for this study was in addition to their current practice. Before providing counselling to fathers, the CHWs and midwives attended a two-day training workshop (see Appendix A for workshop agenda) in April 2014 where they were taught the benefits of exclusive breastfeeding, the importance of attentive and responsive father involvement, and the overall benefits of father involvement related to infant development. They were also taught counselling techniques for client focused consulting to promote empowerment of fathers for involvement in breastfeeding support and direct father-infant interaction. For the purpose of this study, client focused father involvement consulting has been defined as “non-directive counseling that focuses on the fathers’

needs, encourages the fathers to give their own ideas, and enables the fathers to make their own informed decisions about involvement in breastfeeding and in having a relationship with their infants” (see Appendix B for training workshop power point slides).

Another component of the training involved having the CHWs practice each home visit counselling session with one consultant father before continuing with the remaining fathers. When feasible, one or more of these practice sessions were observed by a research team member. The CHW was given the opportunity for self-reflection. The research team member discussed each practice session with the consultant father and the counsellor, either in person or by phone, and provided constructive feedback to the CHW (see Appendix C for CHW training manual). The pilot father observation sessions were completed in May, June, July, August and September of 2014.

The focus of my research study was the evaluation of perceptions of the commune health workers regarding the training process. The goal of this study was to contribute to the knowledge about training for healthcare workers on the topic of father involvement in breastfeeding for future impact on education methods.

Participants

To answer the research questions I conducted a descriptive study in April 2015 with CHWs and midwives who completed the intervention training for the father involvement study (Bich, Rempel et al., 2013). The sample consisted of 26 commune health workers and 2 midwives from the district hospital who attended the same education sessions. The commune health workers included doctors, physician assistants, and nurses.

Design

The design of this study was a one group, post-test only, quasi-experimental design. Data was collected using a structured self-report questionnaire (see Appendix D for questionnaire for CHWs and midwives).

Measures

The questionnaire was developed for the study based on literature reviews about healthcare worker education and Social Cognitive Theory (Bandura, 2004). There were no tools found that were appropriate for this study. Therefore, the questions were developed based on initial research including an SCT questionnaire for healthcare workers about the effectiveness of continuing professional development on clinical behaviour intentions (Legare et al, 2014). Other literature reviewed for ideas included confidence and efficacy scales. The questionnaire for this father involvement study included queries into perceptions related to each aspect of the intervention training process, perceptions related to change in knowledge about client focused consulting and father involvement in breastfeeding, and perceptions of CHWs' ability to transfer that new knowledge to fathers by providing client focused father involvement consulting.

The questionnaire was reviewed by research team members in Canada and then sent to the team members in Vietnam for review. The feedback was discussed and changes made. The questionnaire has undergone a process of translation by two research team members in Vietnam to ensure that the concepts in the items were appropriately translated. A Vietnamese research team member was trained to administer the questionnaires. The team member travelled to each intervention commune to meet with each health worker who completed a counsellor training session. She explained the study

(see Appendix E for the verbal script and Appendix F for the letter of information), obtained consent (see Appendix G for consent), and had each CHW complete the questionnaire, seal it in an included envelope, and return the questionnaire to the research team member. CHWs were given a small payment of \$5 in appreciation for their participation. The research team member returned the sealed envelopes to the Hanoi School of Public Health where they were placed in a locked cabinet. Results were disseminated to participants with a feedback letter (see Appendix I).

Ethics. Prior to administration of the questionnaire, ethics approval was obtained from both Brock University and Hanoi School of Public Health.

Demographics. Demographic information was collected from participants to determine profession, education level, age, and gender. Information was also collected about the use of consultant father observation sessions.

Power and effect size. Since the sample in this study was comprised of a set group of participants who received the father involvement education, there was a risk that the small sample size would negatively affect the power of the study by increasing the chance of type two error (Polit, 2010). Considering the ratio of predictors to cases is one way to handle this issue. Since there was a maximum number of three predictors in the planned regression equations, a low number of participants could produce a large effect size with a power of .80 and an alpha of .05. For example, a significant $R^2 = .30$ can be obtained with 30 participants or $R^2 = .40$ with 21 participants (Polit, 2010). Thus, with a maximum expected sample of 28 participants, this study had sufficient power to detect a significant $R^2 > .30$.

Descriptive statistics. In order to answer the first research question, which asked the perceptions of CHWs about their ability to provide client focused father involvement consulting, descriptive statistics were analyzed and reported.

Theory variables. The second research question asked about the relationship and strength of relationship of SCT to the CHWs' ability to provide client focused father involvement consulting following the education strategy. In order to answer this research question, variables from the Social Cognitive Theory pathway (Bandura, 2004) were assessed using five scales (see Appendix H for the questionnaire organized by theory variables). The predictor variables were: self-efficacy, outcome expectations, sociostructural factors (barriers and facilitators), and goal setting. The outcome variable was the CHW behaviour of client focused father involvement.

Hypotheses

The hypotheses for this study were:

1. Self-efficacy will be correlated with outcome expectations and sociostructural factors (barriers and facilitators).
2. Self-efficacy, outcome expectations and sociostructural factors (barriers and facilitators) will predict goal setting.
3. Self-efficacy, outcome expectations and goal setting will be predictors of CHW behaviour of client focused father involvement consulting.
4. Self-efficacy, outcome expectations, sociostructural factors (barriers and facilitators) will be predictors of CHW behaviour of client focused father involvement consulting.

Measurement Scales

Self-efficacy. Self-efficacy was measured on a 7 point Likert-type scale. Four questions were to be measured in terms of feelings of confidence with questions such as, “How confident are you that you can provide client focused consulting?”, where 1 is ‘not at all confident’ and 7 is ‘very confident’. The remainder of the questions were based on agreement statements where 1 is ‘strongly disagree’ and 7 is ‘strongly agree’. These questions covered issues and their impact on self-efficacy, such as: the training workshop, training manual, teaching methods, observation sessions, support and stress (see Appendix H for items).

Outcome expectations. Outcome expectations included items about perceptions of physical, social and self-evaluative outcomes including aspects of motivation and self-regulation. These were measured on 7 point Likert-type scales with statements such as, “I have greater impact on father-infant involvement when I practice client focused consulting”, with 1 being ‘strongly disagree’ and 7 being ‘strongly agree’. Outcome expectations included impact on father involvement, impact on breastfeeding rates and duration, sustainability, job satisfaction, and positive beliefs about father involvement in breastfeeding (see Appendix H for items).

Sociostructural factors. Sociostructural factors included measurement of barriers and facilitators such as education strategy structure and style (venue, power point slides, discussion), workload, ability to attend sessions, stress, fatigue, support and moral disengagement. These were measured on a 7 point Likert-type scale with statements such as, “Work commitments made it difficult for me to attend the education days”, with 1 being ‘strongly disagree’ and 7 being ‘strongly agree’ (see Appendix H for items).

Goal setting. Future goal setting included measurement of self-regulation and intentions. Goals for CHWs included planning to practice client focused father involvement consulting, planning to use of new knowledge, continuing to seek new knowledge, motivation and self-reflection. These were measured on a 7 point Likert-type scale with statements such as, “I plan to provide client focused father involvement consulting”, with 1 being ‘not at all’ and 7 being ‘always’ (see Appendix G for items).

Behaviour. Present behaviour was measured on a 7 point Likert-type scale and included statements such as, “I help fathers to find solutions to questions about involvement in breastfeeding”, with 1 being ‘never’ and 7 being ‘always’. Behaviour included: provision of more client-focused consulting, focusing on fathers’ needs, asking fathers for their ideas and questions and planning consulting based on these, helping fathers to make their own decisions and plans, and showing respect (see Appendix H for items). Since the questionnaire was completed in April 2015, the CHWs and midwives had at least seven months to be practicing client focused father involvement consulting after the last pilot father session.

Data Analysis

Once the completed questionnaires were collected, data was input into SPSS by a Vietnamese team member and this data file was sent to me for analysis. Data analysis involved calculation of descriptive statistics and Pearson bivariate correlations with 95% confidence intervals between all variables. In order to test the SCT pathway model (Bandura, 2004), the following analyses were conducted.

Bivariate correlations were used to estimate the paths for self-efficacy predicting outcome expectations, self-efficacy predicting barriers and self-efficacy predicting facilitators.

Multiple regressions were based on the SCT pathway (Bandura, 2004) as shown in Figure 2. Multiple regressions were calculated using simultaneous predictor variable entry. The regression models were evaluated using adjusted R^2 and standardized beta weights following examination of statistical assumptions.

A multiple regression was run with self-efficacy, outcome expectations, barriers and facilitators to predict goal setting. The equation for this regression was:

$$\text{Goal setting}_i = b_0 + b_1\text{self-efficacy} + b_2\text{outcome expectations} + b_3\text{barriers} + b_4\text{facilitators} + \text{error}_i$$

The next multiple regression included self-efficacy, outcome expectations and goal setting as predictors of CHW behaviour of client focused father involvement consulting. The equation for this regression was:

$$\text{Behaviour}_i = b_0 + b_1\text{self-efficacy} + b_2\text{outcome expectations} + b_3\text{goal setting} + \text{error}_i$$

A second multiple regression predicting behaviour was conducted recognizing that the goal setting questions in this study asked only about future goals. It is not logical to have a pathway that runs from future goals to present behaviour. Goal setting was therefore removed from the regression equation. This resulted in a multiple regression including self-efficacy, outcome expectations, barriers and facilitators as predictors of behaviour. The equation for this multiple regression was:

$$\text{Behaviour}_i = b_0 + b_1\text{self-efficacy} + b_2\text{outcome expectations} + b_3\text{barriers} + b_4\text{facilitators} + \text{error}_i$$

Chapter 4: Results

Participants and Demographics

All 28 eligible potential participants contributed to the findings of the study. These participants consisted of 26 CHWs (nurses, physicians, and physicians' assistants) and 2 midwives from the district hospital, all of whom chose to complete the questionnaire. See Table 1 for demographic characteristics of the participants. Only 2 midwives were expected but 9 participants chose the profession option "midwife" on the questionnaire. On clarification with the team in Vietnam, it was recognized that many of the nurses are also midwives and chose that option rather than the "nurse" option. The majority of participants were physicians. The next largest groups were midwives and nurses, while physician's assistants were the smallest group represented. The majority of participants had attended university. The mean number of years of education after high school was 4.82 ($SD = 1.93$) with a range of two to seven years. The range of ages of participants was 26 to 55 years. The youngest participants were midwives while the oldest were physician's assistants and physicians. Further analysis of the demographics showed that all of the physicians had attended university and most had attended school for 7 years after high school ($n = 9$), while two had attended for 6 years. Of the nurses attending university, one nurse had 7 years of post-high school education and one had 2 years of post-high school education. The other nurses had attended college for 3 years ($n = 2$) or 2 years ($n = 1$). One midwife had attended university and attended 6 years of school after high school. The remainder of the midwives had attended college for 3 years ($n = 4$) and 4 years ($n = 4$). One of the physician's assistants had attended university, while 2 attended college. The physician's assistants had each attended post-high school education for 3 years. The majority of participants were female (79%). Of the males,

three were physicians, one was a nurse and one was a physician's assistant. On analysis with crosstabs, correlations and ANOVAs there was no significance between age and profession, or for profession and years of schooling, to each variable.

Table 1

Characteristics of Participants

Characteristic	<i>N</i>
Profession	
Nurse	5
Midwife	9
Physician	11
Physician's Assistant	3
Education Level	
Training School	0
College	13
University	15
Number of Years of Education	
2 years	2
3 years	9
4 years	4
6 years	3
7 years	10
Gender	
Female	22
Male	5
Mean Age (<i>SD</i>)	44.86 (<i>SD</i> =7.85)

Note. *N* = 28.

Counsellor Training Experiences

Participants were asked about their participation in the pilot father observation sessions. The overall number of participants who stated they attended a pilot father observation session was 26. It was expected that the district midwives would not have been part of the pilot process because the community father visits were not part of their role in the intervention study. However, only one midwife answered that they did not participate along with one physician. The answers about which sessions had been observed were somewhat unclear. Many of the participants who said they had participated in the observation sessions did not state which session/sessions they had attended. Some participants stated they had participated in April and May ($n = 7$), which was when the prenatal counselling sessions were observed. Others stated they had participated in June and July ($n = 6$), which was when the 1-week and 6-week postpartum visits were observed. Some participants ($n = 4$) stated they had participated in the August and September visit, which was the 3-month postpartum visit.

Theory Constructs

Theory constructs were analyzed for means, standard deviations, minimum and maximum scores and normal distribution. There was no missing data. Each scale was analyzed for Cronbach's α data to assess internal consistency. Item-total correlations were assessed for each item, as well as the effect on α if the item was deleted. Some item-total correlations were low but α 's only changed slightly if items were deleted. Due to the theoretical importance of each question for the program evaluation it was decided to retain all of the questions.

Self-efficacy. The questionnaire included seventeen self-efficacy items. Due to an error on the questionnaire that was detected after this was sent for translation, three of the self-efficacy items were unable to be used. This left a total of fourteen self-efficacy items. See Table 2 for the mean, standard deviation, minimum, maximum and α . Self-efficacy as an overall variable, had a mean of 6.33 ($SD = 0.68$) with a minimum scale value of 4.29 and a maximum value of 7.00 on a Likert-type (1-7) scale. The skewness was -1.43 and the kurtosis was 1.94 meaning that this variable is slightly negatively skewed and leptokurtic (George & Mallery, 2011). Cronbach's α was .87. The self-efficacy items had fairly high scores. The highest scores were for items about the training workshop. The lowest score was for the question, "Providing client focused father involvement consulting is stressful". Five participants chose the answer "strongly disagree, while eight participants chose the answer "strongly agree".

Table 2

Self-Efficacy Scale

Question	Mean (SD)	Minimum	Maximum
1. How confident are you that you can provide client-focused consulting?	6.36 (1.19)	4	7
2. The counsellor training workshop gave me the information I needed to provide counselling about father support of breastfeeding and father-infant relationships.	6.86 (0.45)	5	7
3. The counsellor training manual gave me the information I needed to provide client focused father-involvement consulting.	6.50 (1.35)	1	7
4. The counsellor training workshop increased my confidence in my ability to provide client focused consulting to fathers about involvement in breastfeeding and in relating to their infants.	6.86 (0.59)	4	7

5. Watching a group counselling session at the training workshop increased my confidence in my ability to provide counselling to fathers about involvement in breastfeeding and relating to their infants.	6.79 (0.42)	6	7
6. I would have liked more role play during the training workshop.	5.57 (2.10)	1	7
7. I would have liked more learning based on observation	5.79 (1.64)	7	7
8. Being observed providing counselling to a pilot father increased my confidence.	6.52 (0.94)	4	7
9. Talking to a research team member after the pilot father consulting sessions increased my confidence.	6.70 (0.72)	4	7
10. The involvement of my supervisors and district health staff in the training made me feel supported in providing father involvement consulting.	6.29 (1.12)	4	7
11. The support of my workplace makes me feel more confident in my ability to provide client focused consulting to fathers about involvement in breastfeeding and relating to their infants.	6.57 (0.88)	4	7
12. Meetings with research team members increased my confidence in my ability to provide client focused consulting.	6.71 (0.81)	3	7
13. Group discussions at the workshop helped me think about my own beliefs about father involvement.	6.71 (0.66)	4	7
14. Providing client focused father involvement consulting is stressful.	4.46 (2.30)	1	7
Self-Efficacy Scale ($\alpha = .87$)	6.33 (0.68)	4.3	7

Note: SD = Standard Deviation. α = alpha coefficient (Cronbach, 1951).

Outcome expectations. There were a total of ten questions related to outcome expectations. See Table 3 for the mean, standard deviation, minimum, maximum and α computed for the overall scale. When the questions were combined under this construct, the outcome expectation variable scale mean was 6.65 ($SD = 0.46$). The skewness was

-1.55 and the kurtosis was 2.32. This data is therefore slightly negatively skewed and leptokurtotic (George & Mallery, 2011). The minimum value on the 1 to 7 Likert-type scale was 5.2 and the maximum value was 7. Cronbach's α was .72. The questions within this variable had fairly high scores. The highest item scores were for beliefs and impact on breastfeeding and father involvement, while the lowest scores were for support and sustainability.

Table 3

Outcome Expectations Scale

Question	Mean (SD)	Minimum	Maximum
1. I have greater impact on father-infant involvement when I practice client focused consulting.	6.89 (0.42)	5	7
2. I have greater impact on breastfeeding rates and duration when I practice client focused consulting to support father involvement in breastfeeding.	6.89 (0.42)	5	7
3. I will be able to sustain this practice of client focused father involvement consulting over time.	6.04 (1.55)	1	7
4. Practicing client focused father involvement consulting makes me feel more satisfied in my job.	6.57 (0.88)	4	7
5. I feel a sense of self-worth when I practice client focused father involvement consulting.	6.79 (0.57)	5	7
6. It is important for me to be rewarded by my local and district supervisors for providing client focused father involvement consulting.	5.71 (1.78)	1	7
7. As a result of this education, I now believe more strongly than I did before that exclusive breastfeeding is the right thing to do.	6.89 (0.31)	6	7

8. As a result of this education, I now believe more strongly than I did before that involving fathers in breastfeeding is the right thing to do.	6.93 (0.26)	6	7
9. As a result of this education, I now believe more strongly than I did before that fathers should be more involved in a relationship with their infants.	6.86 (0.45)	5	7
10. As a result of this education, I now believe more strongly than I did before that practicing client focused consulting is the right thing to do.	6.89 (0.31)	6	7
Outcome Expectations Scale ($\alpha = .72$)	6.65 (0.46)	5.2	7

Note: SD = Standard Deviation. α = alpha coefficient (Cronbach, 1951).

Sociostructural factors. Sociostructural factors were divided into two separate subscales of ‘facilitators’ and ‘barriers’. See Tables 4 and 5 for the mean, standard deviation, minimum, maximum and α computed for the overall scale. The facilitators subscale had a mean of 6.76 ($SD = .51$) with a minimum of 4.67 and a maximum of 7. The skewness was -2.96 and the kurtosis was 10.14, which is not normally distributed (George & Mallery, 2011). Cronbach’s α was .91. The barriers subscale had a mean of 4.98 ($SD = 1.49$) with a minimum of 1.86 and a maximum of 7 (7 indicating maximum difficulty). The skewness was -.54 and the kurtosis was -.89. Cronbach’s α was .84. All facilitator scores, including topics of location and environment of the teaching sessions, and discussion and power point slides used in these sessions were similarly high. Barriers with higher scores included work schedules of the participants and fathers while lower scores included travel distance and family life.

Table
4

Facilitators Subscale

Question	Mean (<i>SD</i>)	Minimum	Maximum
1. The power point slides were a facilitator to my learning about client focused father involvement consulting.	6.75 (0.52)	5	7
2. The discussion was a facilitator to my learning about client focused father involvement consulting.	6.79 (0.50)	5	7
3. The location and environment of the training workshop were facilitators to my learning about client focused father involvement consulting.	6.75 (0.65)	4	7
Facilitators Subscale ($\alpha = .91$)	6.76 (0.51)	4.67	7

Note: SD = Standard Deviation. α = alpha coefficient (Cronbach, 1951).

Table 5

Barriers Subscale

Question	Mean (<i>SD</i>)	Minimum	Maximum
1. Work commitments made it difficult for me to attend the training workshop.	5.21 (1.77)	1	7
2. Family life made it difficult for me to attend the training workshop.	4.31 (2.51)	1	7
3. Distance made it difficult for me to attend the training workshop.	4.21 (2.23)	1	7
4. Fatigue made it difficult to learn new knowledge about providing client focused father involvement consulting.	4.82 (2.02)	1	7
5. Personal stress made it difficult to learn new knowledge about providing client focused father involvement consulting.	4.79 (2.30)	1	7
6. Work schedules of the fathers made providing home visits for father involvement consulting difficult.	5.82 (1.72)	1	7
7. Work schedules of the fathers made providing group counselling difficult.	5.68 (1.93)	1	7
Barriers Subscale ($\alpha = .84$)	4.98 (1.49)	1.86	7

Note: SD = Standard Deviation. α = alpha coefficient (Cronbach, 1951).

Goals. There were 6 items pertaining to goal setting on this questionnaire. These items asked about future goals, motivation and reflection relating to client focused father involvement consulting. See Table 6 for each item's mean, standard deviation, minimum, maximum and α . As a construct variable, goals had a mean of 6.28 ($SD = 0.92$) with a minimum of 4 on a 1 to 7 Likert-type scale and a maximum of 7. The skewness was -1.25 and the kurtosis was 0.83 meaning this data is slightly negatively skewed and kurtotic (George & Mallery, 2011). Cronbach's α was .78. The highest

scores were for the items related to motivation and reflection while the lowest scores were for the items related to non-directive consulting.

Table 6

Goals Scale

Question	Mean (<i>SD</i>)	Minimum	Maximum
1. I plan to provide client focused father involvement consulting.	6.36 (1.19)	4	7
2. I plan to continue to learn new knowledge related to father involvement in breastfeeding.	6.43 (1.10)	4	7
3. I plan to provide non-directive consulting that focuses on fathers' needs.	5.39 (2.15)	1	7
4. I plan to help fathers set their own goals for involvement in breastfeeding.	6.25 (1.43)	1	7
5. I reflect on my practice to promote client focused father involvement consulting.	6.57 (0.84)	4	7
6. I feel motivated to provide client focused father involvement consulting.	6.68 (0.72)	4	7
Goals Scale ($\alpha = .78$)	6.28 (0.92)	4	7

Note: SD = Standard Deviation. α = alpha coefficient (Cronbach, 1951).

Behaviour (client focused father involvement consulting). There were 10 items pertaining to the behaviour of client focused father involvement consulting. These items were specific to roles of the consulting that were taught throughout the education strategy. See Table 7 for behaviour scale items with means, standard deviations, minimum, maximum and α . As a whole variable, behaviour had a mean of 5.76 ($SD = 0.50$) with a minimum value of 4.30 on a 1-7 Likert-type scale and a maximum value of 7. The skewness was 0.14 and the kurtosis was 3.62. Cronbach's α was .68. Kline

(1999) posits that while .70 to .80 is an appropriate scale α for ability tests and cognitive tests respectively, when using psychological constructs, an α value of lower than .70 is appropriate. A value as low as .50 may be appropriate with new scales in the initial stages of research (Field, 2013). The highest scores within this construct were for items about helping fathers to make decisions and find solutions. The last two questions in this section were reverse coded and this was accounted for in the data analysis. The mean (before reversal) for the question, “I directly tell fathers what to do to be involved in breastfeeding or with their infants,” was 6.00 ($SD = 1.72$) with a minimum of 1 and a maximum of 7. The question, “I directly tell fathers what goals they should have for involvement in breastfeeding,” had a mean (before reversal) of 6.12 ($SD = 1.69$) with a minimum of 1 and a maximum of 7.

Table 7

Behaviour Scale

Question	Mean (<i>SD</i>)	Minimum	Maximum
1. Since this education, I provide more client focused consulting for fathers than I did before.	6.68 (0.77)	4	7
2. I ask fathers for their ideas about involvement in breastfeeding.	6.75 (0.59)	5	7
3. I add information to my consulting sessions based on what fathers ask or tell me.	6.61 (0.83)	4	7
4. I help fathers to be able to make their own decisions about their involvement.	6.79 (0.50)	5	7
5. I help fathers to find solutions to questions about father involvement.	6.79 (0.69)	4	7
6. I show fathers that I respect their ideas and decisions.	6.75 (0.70)	4	7
7. I focus on fathers' needs when I consult with them.	6.64 (0.83)	4	7
8. I help fathers to make a plan for their involvement.	6.71 (0.66)	4	7
9. I <u>directly tell</u> fathers what to do to be involved in breastfeeding or with their infants.	6.00 (1.72)	1	7
10. I <u>directly tell</u> fathers what goals they should have for involvement in breastfeeding.	6.12 (1.69)	1	7
Behaviour Scale ($\alpha = .68$)	5.76 (0.50)	4.3	7

Note: SD = Standard Deviation. α = alpha coefficient (Cronbach, 1951).

Correlations

One-tailed bivariate correlations were analyzed between the six constructs of self-efficacy, outcome expectations, barriers, facilitators, goals and behaviour (client focused father involvement consulting). The data for each construct does not deviate substantially from normality based on skewness and kurtosis accepted values of -2 to 2 (George & Mallery, 2011). The scatterplots indicate that that relationship between all variables was linear. The cases are independent although this questionnaire did not use random sampling. Based on the fact that the assumptions were met, data for Pearson's r was analyzed. See Table 8 for correlations, significance levels and 95% confidence intervals.

Table 8

Pearson's r correlations with significance levels and 95% confidence intervals

	Self-Efficacy	Outcome Expectations	Barriers	Facilitators	Goals	Behaviour
Outcome Expectations	.65*** [.27, .86]					
Barriers	.29 [.03, .57]	.01 [-.25, .32]				
Facilitators	.81*** [.42, .92]	.50** [-.02, .78]	.15 [-.06, .46]			
Goals	.51** [.21, .79]	.52*** [.10, .82]	.17 [-.20, .54]	.28 [-.24, .62]		
Behaviour	.38* [-.12, .69]	.56*** [.06, .82]	-.47** [-.72, -.12]	.42* [-.04, .66]	.11 [-.47, .70]	

*** $p < .001$. ** $p < .01$. * $p < .05$

Strong correlations in the behavioural sciences are considered to be $r = .50$ and above; moderate correlations are considered to be $r = .30$; weak correlations are considered to be $r = .10$ (Cohen, 1988). Based on this guideline, there were moderate to strong correlations between variables that are consistent with the Social Cognitive Theory pathway (Bandura, 2004).

Multiple Regressions

Goal setting. A multiple regression was run with self-efficacy, outcome expectations, barriers and facilitators to predict goal setting. Residuals deviated slightly from normality. Scatterplots were run to assess for linearity and homoscedasticity. This regression was found to be linear and slightly heteroscedastic. A Durbin-Watson statistic was calculated to assess for independent errors. This statistic was under 3.00, which was acceptable to meet the assumption (Field, 2013). Collinearity, VIF and tolerance statistics were also acceptable to meet the assumption of multicollinearity (Field, 2013). Goal setting was found to have an $R^2 = .38$, and an adjusted $R^2 = .27$ [$F(4, 23) = 3.50, p = .02$]. See Table 9 for B 's, β 's and confidence intervals for each variable. There were no significant predictors of goal setting although self-efficacy had a strong β of .59 ($p = .10$).

Table 9

Goal Setting Regression

Variable	Goals		
	<i>B</i>	β	95% CI
Self-efficacy	.81 ^t	.59 ^t	[-.17, 1.78]
Outcome Expectations	.64	.33	[-.27, 1.56]
Barriers	.03	.04	[-.20, .26]
Facilitators	-.67	-.37	[-1.74, .40]
R^2	.38		
Adjusted R^2	.27		

Note. CI = confidence interval for B value. ^t $p < .10$.

Behaviour. The first multiple regression was conducted to examine the final paths suggested by the SCT pathway, with self-efficacy, outcome expectations and goal

setting predicting behaviour. Behaviour was found to have an $R^2 = .36$ and an adjusted $R^2 = .28$ [$F(3, 24) = 4.49, p = .01$]. See Table 10 for B's, β 's and confidence intervals for each variable. Outcome expectations was the significant predictor of behaviour. The residuals were not normally distributed.

Table 10

Behaviour Regression with Predictor Variables of Self-Efficacy, Outcome Expectations and Goals

Variable	Behaviour		
	B	β	95% CI
Self-efficacy	.09	.12	[-.26, .43]
Outcome Expectations	.68**	.62**	[.18, 1.18]
Goals	-.15	-.27	[-.38, .08]
R^2	.36		
Adjusted R^2	.28		

Note. CI = confidence interval. ** $p < .05$.

A second multiple regression was conducted to examine the adapted SCT model, with goal setting removed and with facilitators and barriers added as direct predictors of behaviour. The residuals were normally distributed. Scatterplots were run to assess for linearity and homoscedasticity. This regression was found to be linear and homoscedastic. A Durbin-Watson statistic was calculated to assess for independent errors. This statistic was less than 2.00 which is acceptable to meet the assumption (Field, 2013). Collinearity, VIF and tolerance statistics were also acceptable to meet the assumption of multicollinearity (Field, 2013). Using this new equation, behaviour had an $R^2 = .60$ and an adjusted $R^2 = .53$ [$F(4, 23) = 8.64, p = .000$]. See Table 11 for B's, β 's and confidence intervals for each variable. Barriers and outcome expectations were the

strongest predictors of behaviour while self-efficacy and facilitators were not strong predictors of the behaviour.

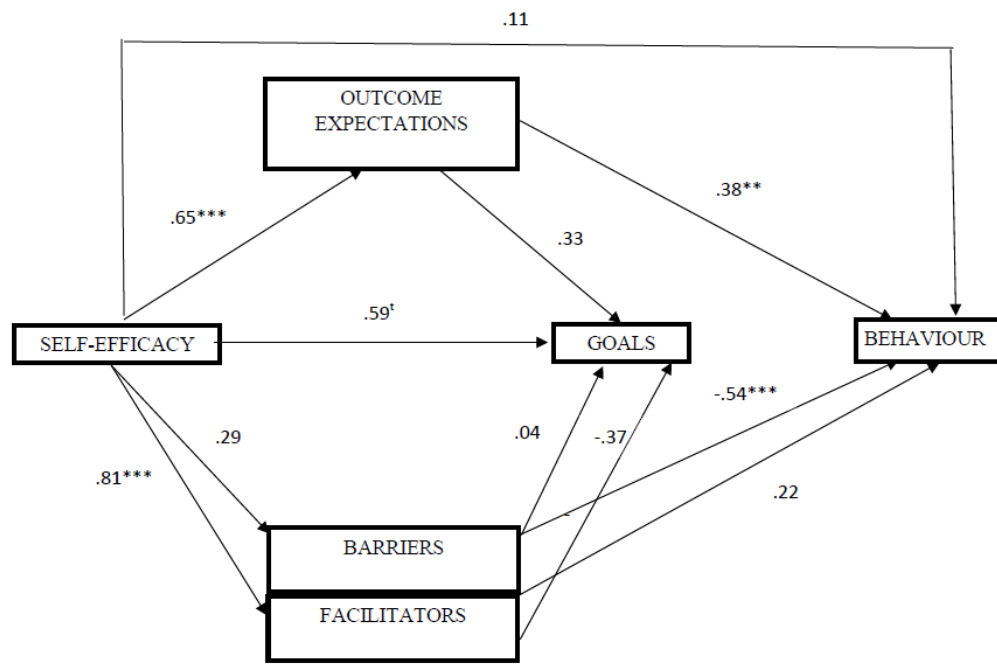
Table 11

Behaviour Regression with Predictor Variables of Self-Efficacy, Outcome Expectations, Barriers and Facilitators

Variable	Behaviour		
	<i>B</i>	B	95% CI
Self-efficacy	.08	.11	[-.35, .51]
Outcome Expectations	.41**	.38**	[.01, .82]
Barriers	-.18***	-.54***	[-.28, -.08]
Facilitators	.22	.22	[-.25, .69]
R^2	.60		
Adjusted R^2	.53		

Note. CI = confidence interval. *** $p < .001$. ** $p < .05$.

Path Model. Figure 3 shows results of the analyses conducted to examine the adapted SCT model in which the path from goal setting to behaviour was removed and direct paths were added from outcome expectations and sociostructural factors (facilitators and barriers).



*** $p < .001$. ** $p < .05$. [†] $p < .10$

Figure 3. Path Analysis

Chapter 5: Discussion

The Social Cognitive Theory (Bandura, 2004) was used to guide the evaluation of the father involvement counselling training. The participants in this study reported perceptions of increased self-efficacy and outcome expectations following the education strategy. They also reported that they are practicing client focused father involvement consulting and have goals to continue this practice. Client focused father involvement consulting could help to improve exclusive breastfeeding rates in Vietnam, as well as throughout the world, if healthcare workers are trained effectively. This chapter discusses findings related to the research questions and hypotheses. Limitations of the study and recommendations for practice, policy, and research are shared.

Theory Constructs

This study was conducted to assess the perceptions of commune health workers about their ability to provide father involvement consulting following an education strategy. The theoretical variables that were assessed in this study were from Bandura's (2004) pathway and included self-efficacy, outcome expectations, sociostructural factors, goal setting and the behaviour of client focused father involvement consulting (see Figure 2). The first research question asked, "Following the father involvement education, how do the CHWs perceive their ability to provide client focused father involvement consulting?" The participants' responses regarding their self-efficacy, outcome expectations, goals and behaviour were used to answer this question. Responses about perceptions of sociostructural factors were used to assess barriers and facilitators to participants' learning and behaviour.

Self-efficacy. Self-efficacy is considered by Bandura, to be the most important construct within his pathway (Bandura, 2004). The participants in this study reported

high levels of self-efficacy about client focused father involvement consulting. The perceptions of the participants were that the teaching strategy, particularly the training workshop, was effective in increasing their self-efficacy in providing client focused father involvement. Strategies used within the workshop that the participants perceived to be of the most help were the meetings with the research team members, group discussions and group counselling sessions. Role play and learning based on observation were considered less helpful for these CHWs. There was a wide range in participants' perceptions of stress from strongly disagreeing that providing father involvement consulting is stressful to strongly agreeing that it is stressful. Because stress and self-efficacy are closely linked by Bandura (2000), this is a topic that could be focused on in future teaching sessions. Stress reactions are reduced when self-efficacy is reinforced (Bandura, 2000). Therefore any education strategy that could improve self-efficacy of the new behaviour could reduce the stress associated with learning about, or performing, the new behaviour. In this context, some suggestions for the teaching strategies include: practicing the new consulting skills thoroughly until CHWs feel more confident, acknowledging and teaching about stress reactions to new learning and behaviours, providing a support system for the CHWs to be able to continue to practice the new behaviour, and providing a system of support if stress becomes overwhelming.

Outcome expectations. Outcome expectations is considered by Bandura (2000) to be another important construct that is highly linked with self-efficacy. A person with high self-efficacy beliefs will also have high outcome expectation beliefs. In order for a healthcare worker to change their practice, they must first believe that their practice will have positive outcomes (Chang & Crowe, 2011). The participants in this study had high

outcome expectations related to father involvement consulting. They agreed with the value of client focused consulting, father involvement and breastfeeding. The participants agreed most strongly with beliefs about father involvement and breastfeeding. Participants showed slightly lower agreement that they would be able to sustain their consulting behaviour. This result could indicate that the participants are somewhat unsure that they will be able to sustain this practice over time. Participants also agreed slightly less that it was important for them to be rewarded by their supervisors, which could indicate that the participants do not place a very high value on rewards coming from the workplace. The participants reported having stronger beliefs, following the education strategy, that involving fathers in breastfeeding is the right thing to do. They also reported a perception that they have greater impact on father-infant involvement and breastfeeding rates and duration following the education strategy. This may indicate a successful education program.

How to gain sustainability will be an interesting question for the future, as will the issue of support from local supervisors. Sustainability is a key component of Graham's Knowledge to Action Process Framework (see Figure 1), and is an important consideration when planning future father involvement education sessions. Sustainability is necessary in order to utilize new knowledge (Graham et al., 2006). It is not enough for healthcare workers to initially learn a new task and complete it, they must be able to sustain this new knowledge and task. Edwards and Roelofs (2006) link sustainability and local support in international health projects. They state that lack of support for training is a major threat to sustainability. When father involvement education is to be conducted, a thorough assessment of the local supervisors' attitudes and commitment to aiding the

healthcare workers' ability to train and then sustain the training would be helpful.

Structures such as policies for support of new learning need to be in place to support sustainability (Edwards & Roelofs, 2006). In a model for sustainability of interventions, the needed processes are listed as: the ability of the program to be adapted as needed, ongoing assessment of the program, leadership and collaboration. If these processes occur then the new program or learning can be sustained (Leffers & Mitchell, 2010). For this new practice of client focused father involvement consulting to be sustained in Vietnam, these same processes will need to be implemented.

Barriers. The barriers identified by the participants in this study may reflect general barriers that will need to be addressed while planning a future father involvement education strategy. The scores on items within this construct had a wider range than within the other constructs, perhaps demonstrating differences between participants regarding their own personal challenges or circumstances. Participants perceived the most difficult barriers to attending the education session and to providing client focused father involvement consulting to be their own work schedules and the work schedules of the fathers. Barriers need to be identified and reduced when planning an education session (Graham et al., 2006). Bandura (2000) lists potential challenges such as fatigue, lack of interest, economic problems, stress and lack of support as some of the barriers to achieving the desired behaviour. Other authors have included time, distance, family responsibilities, other commitments and peer opinion to be barriers in healthcare education (Penz et al., 2007, Schweitzer & Krassa, 2010). These are similar barriers to those discussed in this study. Some ways to reduce these barriers in education include: holding webcasts or teleconferences as opposed to attending in-person sessions, having a

dedicated educator travel to health centres rather than have healthcare workers travel to a session, having learning plans created by each healthcare worker so educators can more precisely target learning needs, and having education opportunities funded by sponsors or provide compensation for staff time and travel (Schweitzer & Krassa, 2010). Barriers are important to address in this context so that healthcare workers can attend an education strategy and effectively learn about father involvement in order to be able to provide client focused father involvement consulting. The issue of work schedules of the participants and the fathers is a specific problem related to father involvement education that would need to be addressed. These two barriers could be addressed during the education session so that participants can, with guidance, find solutions based on their own availability and their knowledge of their clients and communities.

Facilitators. The father involvement counselling education strategy was perceived by the participants to be a strong facilitator for their learning about father involvement consulting. The scores indicate that the perceived facilitators were: the discussion, the power point presentation, the location and environment of the training workshop. As shown in Graham's model (see Figure 1), during the planning of an education strategy, teaching and learning methods appropriate for the context and the participants need to be assessed. General information related to father involvement education can be altered to fit any local context and demographic. The participants in this study represented a range of age and professions including physicians, physicians' assistants, nurses and midwives. In this study there were no significant differences to participants' perceived learning based on age or profession. However, in other groups

there may be teaching strategies that are more effective for a specific age group or profession.

This is an important factor to consider when planning future education strategies. When planning an education strategy, adult learning principles need to be considered. Adult learning has the focus of changing values, beliefs, skills and behaviour and may be done in a variety of ways (Caffarella & Daffron, 2013). There are five main adult learning principles as described by Holyoke (2007). The first is that adult learners need to know why they are asked to learn something new. They want to know the reasons behind the change in practice or knowledge. If they understand the reasoning they are more likely to perform the behaviour. This links very well with Bandura's (2004) ideas of outcome expectations, which significantly predicted counsellors reported use of client centred father involvement counselling behaviours. The second principle is that of autonomy. Adult learners need to be able to feel that they can be self-directed and have a dynamic interest in their own learning, which links to Bandura's (2000) ideas on self-regulation. For a workshop such as the ones done in Vietnam, this could involve giving the CHWs choices of learning topics or learning methods. It also involves the self-reflection of the CHWs for continued change in practice. The third principle is that adult learners bring many values and beliefs from previous life experiences. It is important to take these past experiences into consideration. Issues arising from these experiences may need to be addressed during the education (Caffarella & Daffron, 2013). In this context, allowing for a debriefing time to discuss attitudes towards breastfeeding, father involvement, and consulting methods is beneficial. This was done in the training workshop in Vietnam but could potentially also be done during the initial implementation

phase for father involvement consulting as a method for sustainability. The fourth principle of adult learning as discussed by Holyoke (2007) is that of a readiness to learn. Adult learners must find the learning experience useful, interesting, and related to their lives or careers. In this context in Vietnam, the CHWs and midwives were learning information directly related to their careers. The fifth principle is that adult learners must be provided with practical and applicable learning. During this workshop the participants were able to practice new consulting skills, which they reported were useful for their self-efficacy in providing this skill on return to their community. The last principle of adult learning is that of internal motivation. Adult learners must feel internally motivated to effectively learn and implement new knowledge and skills. This is also an important concept to Bandura (2000). In this study, goal setting questions were asked but it is recommended that questions be added about internal motivation. Applying these appropriate teaching and learning principles may be a facilitator to healthcare workers' learning in future father involvement education strategies.

Goals. Goal setting is a key construct in the Social Cognitive Theory (Bandura, 2004) as it is a part of self-regulation, along with self-efficacy and outcome expectations. Goal setting includes being able to assess oneself and commit to change (Bandura, 2000). The participants in this study perceived that they are motivated, and plan to provide client focused consulting, they reflect on their practice, and they plan to learn new knowledge related to this topic. There was, however, a wide range of answers regarding the plan to provide non-directive counselling. As presented to the CHWs and midwives (see Appendix B), non-directive counselling is client focused and supportive. The counsellor shows respect to the client and helps them to develop skills and make their own

decisions. It is not critical or imposing, does not include advice-giving or telling the client what they should do. The participant responses regarding their goals for non-directive counselling ranged from not planning to provide non-directive counselling at all to always planning to provide non-directive counselling. This could indicate that some of the participants do not intend to practice non-directive counselling or it could indicate that they did not understand the question or the meaning of non-directive counselling. This healthcare education in Vietnam aimed to teach non-directive counselling in order to change the focus from practitioner-directed counselling to client focused counselling. Traditional learning in Asian countries is often passive (Chen, 2014) where the teacher, or healthcare provider, is seen as the authority on the subject. The practitioners will prepare information and provide it in a lecture style while the learner, or client, simply listens. This is in contrast to Western thinking, which involves teaching the client autonomy in learning and in making their own decisions (Chen, 2014). It is the non-directive counselling or teaching approach that is a key component in breastfeeding education and it is important that future education strategies contain this education (Buskens & Jaffe, 2008). In countries such as Vietnam where directive consulting is a cultural norm, this cultural issue becomes a barrier to behaviour change. For healthcare workers, reinforcing the research behind the need for non-directive consulting may help to overcome this barrier. Also, a great deal of practice providing this consulting may be helpful.

Behaviour. Participants' reports indicated that they believed they had high levels of client focused father involvement consulting behaviour after this education strategy. Participants strongly perceived that they were providing the elements of this behaviour

such as: helping fathers to find solutions and make decisions, asking fathers for ideas, showing fathers respect, and focusing on fathers' needs. There were no significant correlations between age or profession and the behaviour, showing that all professions and ages responded similarly to the education. Results for two of the behaviour items indicate that most of the participants were regularly 'directly telling' fathers what to do and what goals to make, when the education strategy was teaching that 'directly telling' is not part of client focused consulting. The desired mean for these questions would have been on the other end of the scale. These results could indicate that the participants were confused by the reverse coding of these questions. It could also indicate that they do indeed continue to use directive counselling even after the education session. In that case it will be important for non-directive counselling to continue to be a major focus of future education sessions. The overall high scores throughout this variable, however, indicate that the participants perceive that they have been providing the aspects of client focused father involvement consulting following the education strategy.

Hypotheses on the Relationships of the Social Cognitive Theory Variables

This study was designed to determine whether the behaviour of client focused father involvement consulting could be explained by the Social Cognitive Theory (Bandura, 2004) following an education strategy. The second research question asked, "What are the relationships, and the strengths of the relationships, between the SCT variables (Bandura, 2004) and CHW behaviour of client focused father involvement consulting following the father involvement education?"

Hypothesis 1. It was hypothesized that self-efficacy would be correlated with outcome expectations and sociostructural factors including barriers and facilitators. This

hypothesis was partially supported. Self-efficacy was highly correlated with outcome expectations. When sociostructural factors was divided into barriers and facilitators, self-efficacy was highly correlated with facilitators. Self-efficacy was not significantly correlated with barriers, but the correlation may have been significant with a larger sample. The correlation indicated a positive relationship between self-efficacy and barriers, which is not expected by Bandura. Bandura (2000) discussed the importance of self-efficacy on sociostructural factors and outcome expectations, specifically that the higher the levels of self-efficacy, the greater the ability to overcome barriers. If this questionnaire were to be used for future father involvement education evaluation, the barrier questions should be reassessed and targeted to the specific learning strategy. These barrier questions were mostly about the education workshop and learning new knowledge. They did not ask about barriers to the behaviour directly. This would be a good addition to the questionnaire and may lead to a more significant relationship between self-efficacy and barriers.

Bandura (2000) also discussed that the higher the levels of self-efficacy, the higher the levels of outcome expectations. In this study, the participants reported high levels of self-efficacy following the education session where they learned about the benefits of, and skills for, father involvement consulting. The participants also reported high levels of outcome expectations, as well as high scores for the facilitators to their learning. The associations between self-efficacy and outcome expectations may indicate that the education strategy led to high levels of self-efficacy which led the participants to have strong beliefs about the benefits of father involvement consulting.

Hypothesis 2. The second hypothesis stated that self-efficacy, outcome expectations and sociostructural factors, including barriers and facilitators, would predict goal setting. This hypothesis was supported. Goal setting had 38% of its variance accounted for by self-efficacy, outcome expectations, barriers and facilitators in this sample. If this study were to be generalized, then 27% of the variance in goal setting would be accounted for by the predictor variables. Self-efficacy had greater impact on the variance in goal setting than did outcome expectations or the sociostructural factors. The levels of self-efficacy reported by participants highly predicted their goal setting which is consistent with Bandura (2004). The levels of reported outcome expectations strongly predicted affected goal setting. This indicates that, in this study, the higher the self-efficacy and outcome expectation beliefs, the higher the level of goal setting. If an education session can successfully increase confidence in a skill or ability and increase the belief in the positive outcome of that skill, then the participants may be more likely to set goals to achieve this skill or behaviour.

Hypothesis 3. This hypothesis stated that self-efficacy, outcome expectations and goal setting would be predictors of the behaviour of client focused father involvement consulting. This hypothesis was supported and 36% of the variance on the behaviour was accounted for by the predictor variables. If this study was to be generalized, then 28% of the variance in behaviour would be accounted for by the predictor variables. However, the only significant β value was that of outcome expectations. This is an unexpected result because of the importance that Bandura places on self-efficacy as a predictor of behaviour. A reason for this result could be related to a measurement problem with the scale. The loss of the confidence scale questions could have affected

the ability of the scale to appropriately reflect self-efficacy. It could also be related to the fact that the goal setting questions were asked about future goals and this affected the relationship of goals predicting behaviour in this analysis. Furthermore, self-efficacy was fairly strongly correlated with goals, which likely lowered the effect of self-efficacy on behaviour.

Hypothesis 4. This hypothesis stated that self-efficacy, outcome expectations, sociostructural factors, including barriers and facilitators, would be predictors of the behaviour of client focused father involvement consulting. This hypothesis was supported. This hypothesis is adapted from the original SCT pathway (Bandura, 2004) and was created because the goal questions on the questionnaire were asked at the same time point as the behaviour questions and asked about future goals as opposed to past goals. To properly test the relationship between goals for the behaviour and the actual behaviour, the goal questions would have needed to be asked prior to asking about the behaviour. This may have altered the role of goal setting. It was, therefore, decided to remove goal setting from the regression. Because barriers and facilitators should have been expected to affect behaviour through goal setting, they were added to this regression.

In this new regression model, self-efficacy, outcome expectations, barriers and facilitators accounted for 60% of the variance in behaviour, whereas if generalized to the population, 53% of the variance would be accounted for by these predictors. Barriers and outcome expectations strongly predicted behaviour. Barriers to the learning and practice of father involvement consulting, which included work schedule issues, fatigue, stress, family life issues and travel, strongly negatively affected client focused father

involvement consulting. The ability to learn about, and practice, client focused father involvement consulting would be increased if these barriers were reduced. Stronger beliefs about the effect of practicing father involvement consulting may have positively affected the practice itself. The more the participants believed they would positively affect father involvement and breastfeeding rates and duration, as well as their own personal belief system and satisfaction, the more they reported they practice father involvement consulting.

Barriers and outcome expectations are expected by Bandura (2000, 2004) to be related to the behaviour outcome, although he suggests that the effect of barriers on behaviour should be mediated by goal setting. The amount of variance accounted for by self-efficacy was lower than expected and could be attributed to partial mediation of the effect of self-efficacy on behaviour through the effect of self-efficacy on barriers and outcome expectations, since self-efficacy is shown by Bandura (2004) to affect behaviour both on its own and through the other constructs. The self-efficacy scale may have been affected by the loss of the three confidence questions. The complete questionnaire should be used with a larger number of participants to reassess its validity in predicting client focused father involvement consulting. It is also important to remember the role of reciprocal determinism in this model. Bandura's (2004) model is dynamic and the constructs may interact with each other, showing relationships but not direction of the relationships.

Limitations

There were some limitations to this study. The questionnaire was created for this study because there was a research gap in this area, and as a new questionnaire some

limitations were noted. One such limitation was found in the wording of some of the questions. For example, in this study, the number of midwives was surprising as only two midwives were expected. Upon clarification with the team member in Vietnam, it was noted that the CHWs who practice as nurses are often also midwives. This accounts for the number of midwives, as seven CHWs chose the option “midwife” rather than “nurse”. In future research, it might be important for questions to be made more specific about professional distinctions related to nurses, nurse-midwives, and midwives. The question asking about the pilot father observation sessions was also unclear. In the future this question could be altered to give participants options to circle rather than free text as this led to confusion with dates. However, as this question was specific to the current Saving Brains study in Vietnam (Bich, Rempel, Rempel, & Hoa, 2013) it may not be needed in the future. The reverse coded questions in this questionnaire may have been confusing for the participants. For further use, reverse coded questions could be reworded into positive statements. Another limitation was the loss of three self-efficacy questions, which may have been useful to the self-efficacy scale. If this questionnaire had been back-translated, this error would likely have been noticed and corrected.

This questionnaire should be reassessed for construct representation. For example, the barrier and facilitator questions should include questions related directly to the provision of the behaviour, not just to the workshop. Another example is that the goal setting questions should include internal motivation questions directly related to the behaviour.

Another limitation was the questionnaire being done at one time point. This study is a cross-sectional study, which precludes definitive causal statements.

Furthermore, the cross-sectional nature of the study affected our ability to test the SCT pathway. A major recommendation for use of the questionnaire is that it be completed by participants at two time points if it is being used to test the SCT pathway (Bandura, 2004) and assess the relationships of the constructs with both goals and behaviours. This would more appropriately assess the relationship between goals and behaviour but may also improve the relationship of self-efficacy on behaviour. The first time point could be shortly after the education session and would ask about goals for this behaviour. At this time point the survey could also ask the self-efficacy, outcome expectation, barriers and facilitator questions that relate to the education session. The next questionnaire would be done in the months following the education and would ask the rest of the questions. This would allow for the correct order of the pathway as proposed by Bandura (2004). Other options are also possible. For example, the first questionnaire could be completed a month after the workshop to allow the participants time to process the information. This may also reduce the level of social desirability following an education session.

Another issue that may have been a limitation to this study is that of social desirability, which involves participants answering questions in a socially acceptable manner. This may be of concern in this culture. Vietnam is a collectivist society and as such the healthcare workers may be more likely to respond to questions in a socially desirable manner (Lalwani, Shavitt & Johnson, 2006). Throughout the questionnaire, responses were very high. Though anonymity was maintained during data collection, there is still the possibility that these participants might have answered with high scores because they felt they should. A further limitation to the study may have been the small sample size.

Recommendations for Practice

The information found through this data suggests that the participants perceived the education strategy to be successful in increasing their self-efficacy, outcome expectations and behaviour of client focused father involvement consulting. The information gained reinforces the use of power point slides, group discussion, group counselling sessions, and meeting with the educators. A barrier that will need to be accounted for in future father involvement education strategies is the work schedules of the participants. Also, the barrier of work schedules of fathers needs to be addressed when educating health care workers about teaching involvement to fathers. Based on this data, topics that need to be strongly addressed in future education strategies include: stress of the participants, non-directive counselling skills, and sustainability of the knowledge and skills. These topics are highly important to the success of father involvement consulting. The Social Cognitive Theory (Bandura, 2004), as used along with Graham's framework (Sudsawad, 2007), can be argued to be a good guide for evaluating an education strategy about client focused father involvement consulting. The use of the combined theories added to the body of knowledge about the Social Cognitive Theory by putting the SCT into the Knowledge to Action context for this education strategy. The questionnaire developed for this study can be used to evaluate future education strategies on father involvement, both for scaling up the study in Vietnam and also within other countries. The questionnaire is not culturally specific and, as such, it can be altered to fit any education strategy by making each question specific to the environment and desired behaviour outcome.

The information from this study will be shared with the research team through an interactive web seminar. This information will be of use in improving teaching strategies for scale-up of the intervention in other districts of Vietnam and potentially other countries. Dissemination to a broader audience will include conference presentations and a journal article.

Conclusion

This is one of the first studies to evaluate father involvement education and, as such, provides the research community with new and valuable information. This research project adds to the limited, but growing, body of knowledge about father involvement consulting and education by providing an evaluation tool that could be used in the future. This study also adds insight into the teaching methods that may be useful in future education strategies while suggesting frameworks to aid planning and evaluation of the strategies. In the future, evaluation of father involvement education should be conducted with a larger sample size to reinforce important findings. Based on the literature reviewed on father involvement and breastfeeding, it is hoped that further father involvement education would be conducted worldwide to aid the promotion of father involvement and exclusive breastfeeding practices.

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Appendix A
Training Workshop Agenda

Time	Contents	Responsibility
Day 1 - Morning		
7.30 – 8.00	Registration	Organizer
8.00 – 8.30	Opening	Local leader - Organizer
8.30 – 9.00	Introduction of the project Objectives of the course	Bich
9.00 – 9.45	Parenting team concept and father involvement principles	Bich (written by John)
<i>9.45 – 10.00</i>	<i>Tea break</i>	
10.00 – 10.45	Discussion: <ul style="list-style-type: none"> - Belief about father involvement/fathers roles among HW and HH members - Personal experiences with father involvement (observation in the area) - What should be an appropriate role of fathers in the family at this present time? 	Bich and All
11.00 – 11.30	Group presentation	Team: Hoa, Nghia and Bich
<i>11.30 – 13.30</i>	<i>Lunch</i>	
Afternoon		
13.30 – 14.30	Father Involvement and Child Development: Intervention content	Hoa (written by Lynn)
14.30 – 15.00	Group presentation theory	Nghia
15.00 – 15.15	Tea break	
15.15 – 15.45	Case studies	Group working
15.45 – 16.15	Group presentation	Hoa – Nghia
16.15 – 16.30	Q and A Summary Day 1	Hoa – Nghia
Day 2 - Morning		

8.0 – 9.00	Breast feeding: Benefit; Overcome difficulties	Hoa
9.00 – 9.30	Father involvement in breast feeding	Hoa
10.00 – 10.15	<i>Tea break</i>	
10.15 – 10.45	Sharing stories about father involvement with theirs or others children	
10.45 – 11.30	Counseling skill theory	Nghia
11.30 – 13.30	<i>Lunch</i>	
Afternoon	<i>Move to Commune Health Center</i>	
13.30 – 14.00	Group teaching preparation and practice	Nghia – Kien – Le
14.00 – 15:00	Counseling practice	Group working
15.00 – 15.15	<i>Tea break</i>	
15.15 – 15.45	Group presentation to pilot fathers	
15.45 – 16.15	Reflection and discussion with fathers and CHWs regarding pilot father presentation	Hoa, Nghia, Lynn, John
16.15 – 16.25	Post-test	Organizers
16.25 – 16.40	Closing Inform counselors to schedule first group counseling in second week of May in order to counsel fathers whose babies are due in second and third weeks of June	Organizers

Appendix B

Training Workshop Power Point Presentations: Father Involvement and the Parenting Team

Father Involvement Principles: The Parenting Team

The benefits of father involvement

- The children of involved fathers show:
 - cognitive and intellectual benefits
 - emotional and mental health benefits
 - social and interpersonal benefits
- BUT the father's involvement must be of good quality

A good relationship: Working together as a team

- be like an effective two-person sports team
- both partners are personally invested in reaching a shared **common goal**
- **each person is important** and each must do his or her part but both partners need to be **flexible and able to adapt** to whatever role the situation requires

Working together as a team

- **trust the partner** and give them the space they need – **coordinate your efforts** and only **step in and assist if necessary**
- **communicate** in words and actions – **pay attention** to each other and be **sensitive** to cues so that you can respond as needed
- **praise and encourage** when things are going well, **affirm and comfort** when there has been a mistake

A good relationship: Spending time together

- spending time makes baby feel loved
- father will learn about what his baby likes and needs
- even if a father cannot be with his baby a lot, he should take time when he gets the chance – the baby will notice

A good relationship: Warmth and Caring

- babies are unique, special people – small people with a lot of growing to do, but still people with unique characteristics and “personality”
- babies feel secure when fathers hold them
- a father who can share his emotions creates a happier, more caring home for his baby

A good relationship: Sensitivity and Responsiveness

- pay attention to find out what the baby needs or would like
- respond in a way that meets the baby's needs
- pay attention to how the baby reacts – is the baby happy?
- if not, try again

A good relationship: touch

- touch helps a baby learn to cope with physical and emotional stress – with less stress the body and brain develop better
- touch happens when fathers take care of, play with and spend time together with their baby

A good relationship: talk

- use loving, caring words
- talking and singing stimulates a baby's brain
- babies hear the sounds that they will need to use to learn to talk
- read – even if the baby doesn't understand what the father is saying, the baby is learning and can enjoy time with the father

A good relationship: exploring and learning

- babies must learn to do things for themselves
- repeating activities help babies learn
- try new things that are not too difficult
- babies need to learn new ways of using their bodies
 - babies learn by holding and putting things in their mouth
 - help babies play on their tummy and sit up

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A good relationship: play

- there are many ways to play with a baby
- fathers can be entertainers – funny faces, silly voices, peek-a-boo, etc.
- sometimes a father can have the baby nearby and just watch

A good relationship: gentle control

- fathers will sometimes need to correct a baby's actions if the baby is doing something inappropriate or dangerous
- babies are not deliberately naughty or disobedient – sometimes they will have to be redirected many times before they learn
- treat the baby gently – roughly shaking a baby can damage the baby's brain

A good relationship: protection and physical needs

- keeping his family safe and healthy and helping to provide for their physical needs will always be an important part of a father's job
- work together with the mother to create a safe, clean environment
- go along to health visits and help care for the baby when she is ill

Basic Principles of Good Father Involvement

- take time to develop and nurture a warm, caring, trusting, and respectful relationship with his wife and child
- communicates with his wife to find a unique, couple-specific way in which the two of them can work together as a parenting team
- pays attention to his wife and child, is sensitive to their needs, and responds in ways that are best for mother and child and actually meets their needs

Training Workshop Power Point Presentations: Father Involvement and Infant Development

Father Involvement and Infant Development

Father Involvement Principles

In order to thrive, children need a father who:

- a) takes time to develop and nurture warm, caring, trusting, and respectful relationships with his wife and child
- b) communicates with his wife to find a unique, couple-specific way in which the two of them can work together as a parenting team
- c) is attentive and sensitive to what his wife and child need and responds in ways that are best for mother and child

Counseling Guidelines

- Suggested guidelines for each home visit counseling session
- Training manual has:
 - Information about mother and child characteristics
 - Some suggestions for what father can do
- Always ask the father for his ideas before telling him what to do
- Add information based on what the father says

Prenatal Counselling

- Should occur at approximately 32 weeks fetal gestation
- Mother and child characteristics
 - Baby grows faster and has more movements
 - Mother gains more weight and feels more tired
 - Signs that mean father should take mother immediately to see doctor
 - Signs of labor

Prenatal Counseling

- Things fathers should do
 - *Talk to wife* about how he might be able to help her, e.g., doing hard work for her; helping her be more comfortable, gentle back massage if she has a sore back.
 - Ask if she has any worries about the birth, breastfeeding or being a mother.
 - *Talk to wife* about how they will take care of the baby together.
 - Talk about the ways he would like to interact with his baby (e.g., holding and cuddling baby, talking to baby).
 - If working away from home, call home or come back home more often.

Prenatal Counseling

- Things fathers should do
 - Not take wife out far from home in this period.
 - Take wife to do prenatal check-ups before giving birth and get tetanus injection, if needed.
 - Prepare for the delivery: Be with wife during the delivery, discuss together to choose maternity hospital.
 - Discuss with wife about having sex—she might feel too tired or uncomfortable sometimes. Let her know he understands if she does not want sex as often; abstain if wife had a history of miscarriage or premature delivery

At Birth Counseling

- Should occur before parents leave delivery hospital or clinic
- Mother characteristics
 - Mother may be tired after delivering but happy as she now has a healthy baby.
 - Mother may suffer from uterus contractions or from interventions during delivery.
 - Some mothers may feel sad because they did not have a son or a daughter as expected

At Birth Counseling

- Child characteristics
 - Just few babies are born prematurely or suffered from asphyxia during delivery. These babies need special care.
 - Newborn infants can focus about 30 cm away, like to look at faces and eyes, can imitate facial expressions like sticking out the tongue.
 - Babies have reflexes such as finger and toe grasp, walking movements if feet are touched.

At Birth Counseling

- Things fathers should do for wife
 - Listen to wife if she worries. Help her think about how to solve problems or reduce worries.
 - If wife hurts much, has any difficulties in breastfeeding or has any health problems after delivery, ask doctors immediately.

At Birth Counseling

- Give father the personalized Father-Infant Relationship Calendar
 - Show guidelines and principles on last page of calendar
 - Explain purposes of Father-Infant Relationship Calendar
 - Help father know how his baby will change and develop during the first year (Month 1, month 2 - 3, month 4 - 6, month 7 - 9 and month 10 - 12).
 - Gives some ideas about what he should do to help the baby develop well by supporting his wife in exclusive breastfeeding and by interacting with his baby.
 - Doing what is suggested in this Calendar will help father create an emotional attachment between him and his baby.

At Birth Counseling

- Explain how to use the Father-Infant Relationship Calendar
 - In order to meet his baby's needs, a father needs to pay attention to what his baby is doing at each stage.
 - The Calendar encourages fathers to pay attention to his baby through observing and jotting down the time points when his baby performs his/her developmental milestones at a certain age range.
 - There are special blank places on the Calendar for him to write down the developmental changes his baby does and the activities he does with his baby.

- It is fun take photos of activities fathers do to get involved with his baby. Fathers might take their own photos and ask mother or relatives to take photos of him being involved with his infant.
- There are spaces on the Calendar for fathers to paste the photos he takes during this first year. The photos will indicate his actions taken in supporting his baby's development.
- The full completed calendar will be a good memory about very first days of his child's life.
- Also a piece of evidence showing how much he cares about his beloved child.

At Birth Counseling

- Have father sit and hold his baby and say:
 - Your baby can imitate your face, but you need to have patience—it might take a minute. Try it.
 - Your baby can hold your finger. Try it.
 - Your baby will move his legs when you touch his feet. Try it.
 - Your baby talks to you by making little noises and by crying. You will learn what your baby's cries are telling you.
 - Your baby likes to be touched, cuddled, and talked to.
- Show the dad a napkin to see what the meconium and urine look like.

7-day Post-Birth Counseling

- Arrange for as close as feasible to 7 days post-birth
- Mother and child characteristics
 - Mother can be suffered from vaginal bleeding, stomachache, perineal pain, tiredness, headache or dizzy.
 - Baby: in this period, baby has to face with many risks for his health, such as: low body temperature, low blood sugar, being infected and some special neonatal problems as umbilicus bleeding, jaundice, skin or eye infection
 - Baby may have the phenomenon of "physiological weight loss"

7-Day Post-Birth Counseling

- Help father prepare for first month interaction
 - <http://www.youtube.com/watch?v=z5mJemSOPx8&list=PL173D1EF762687131>
 - Remind father to *work as a team* with wife to take care of the baby.
 - Ask father for his ideas of what he likes to do with baby.
 - Encourage father to *discuss* with wife about good ways for him to spend time with baby, such as changing diapers, bathing baby, holding baby, talking and singing, playing with the baby, etc.
 - Refer to Father-Infant Relationship calendar for ideas of what to do with the baby.



6-Week Post-Birth Counseling

- Arrange as close as feasible to 42 days post birth
- Mother and child characteristics
 - Mother's body is coming back to normal. She has adapted with parenting and taking care of the baby.
 - Baby can track moving objects, talking people.
 - Baby will bat at colorful objects.
 - Baby starts cooing.
 - Sleep more at night than day.

6-Week Post-Birth Counseling

- Help father prepare for next 2 months
 - Ask father for ideas of what he could do with his baby.
 - Suggestions:
 - Talk to baby, wait for your baby to respond with a sound or face movements. Baby will look at father's face. Father should watch baby's face and imitate baby.
 - Show baby interesting and colorful objects—babies do not need toys—things in the house will do.
 - Try baby aerobics. Gently move baby's arms in and out and then legs up and down. Talk or sing while moving baby.
 - Try baby massage.
 - Remember that babies get tired of playing and will turn away, make a face, or begin to cry when she needs to rest.
 - Baby will love to be cuddled and carried around. This will help baby feel safe and happy.

Months 2 to 3

I discuss with my wife how to raise our baby.

I shared my baby her home and talked her about where she will grow up.

The first time my baby rolled over while I was with her was _____.

My baby likes to be in the water when I give her a bath.

My baby lets me know what she wants or needs.

I and my wife agree that we will not feed our baby any food or drink but breastfeed.

My baby likes to look at moving objects.

The first "word" my baby said to me was _____.

My baby's favorite toy is _____.

The first time my baby laughed with me was _____.

My baby likes to talk to me.

My baby's favorite color is _____.

I like to comfort my baby.

My baby is happy when she sees me and sometimes cries when I leave her.

My baby puts everything in her mouth.

The first time my baby held a toy was _____.

My baby likes to hold my hand.

The first time I saw my baby sit up was _____.

I imitate my baby's sounds.

3 ½ Months Post-Birth Counseling

- Arrange as close as feasible to 15 weeks post-birth
- Mother and child characteristics:
 - Mother is fully recovered and can do things as normal.
 - Baby nurses more, grows fast. His weight can be 1.5 times higher than that when he was born.
 - Baby can roll over, play more, grab things.
 - Baby smiles, makes sounds like ma or ba, can imitate sounds, laughs.

3 ½ Months Post-Birth Counseling

- Help father prepare for next 2 months
 - <http://www.youtube.com/watch?v=GixzEBrQQMs&list=PL173D1EF762687131>
 - Ask father for ideas of what he could do with his baby.
 - Suggestions:
 - Pay attention to baby and respond to what baby likes to do.
 - Baby likes to hold interesting objects like a ball, a stuffed animal, a book made of cloth, or a plastic cup.
 - Babies put everything in their mouths, so make sure the toys or objects are clean, not sharp, and are too big to choke on.
 - Play with baby on a blanket on the floor.
 - Walk around with baby or look in a mirror together. Talk about what they see and do. Remind father to remember to take turns and let baby "talk" with him.

Months 4 to 6

I discuss with my wife how to raise our baby.

The first time my baby sat with my help was _____.

My baby makes many word sounds.

My baby's favorite "word" is _____.

I and my wife agree that we will not feed our baby any food or drink but breastfeed.

My baby is interested in other people and wants to participate in conversation.

My baby's favorite song is _____.

I explain to my baby about what is happening around her.

My baby's favorite toy is _____.

I play with my baby when she wants me to.

My baby chews on everything.

I read books to my baby.

My baby's favorite television show is _____.

My baby knows her name.

I imitate my baby's actions.

My baby can point to what she wants.

I saw my baby's first tooth on _____.

The first time my baby waved her hand to say goodbye when I left was _____.

I put my baby to bed.

Training Workshop Power Point Presentations: Consulting Methods



CONSULTING METHOD

*Presenter:
Dang Thi Nghia*

DEFINING CONSULTING

*The process of **exchanging** information to help one person, a group to be able to understand a health status and other related issues, to believe in oneself, to find the best solution **to make the decision by themselves.***

PURPOSE

Support a person, a group

- To develop the skills to assess self's related issues and other relations to be able to take accurate and timely decisions.
- To change the practice to be able to have wanted results.

DIRECTION

- Exchange, cooperation, respect.
- Client is the focus: needs, issues, background...
- The issues that need consultant are the main objective.
- The consultant process must respect the culture, social background and belief of the clients.
- Make question, get information, make plan → take the most suitable plan.



Consulting is not:

- Directing or imposing
- Giving advices
- Chatting
- Interrogation



Consulting

- Personal and private
- Exchange with a person or small group
- Small scale
- Strong emotional impacts.

Communication and health education

- Community
- A large group
- Great hall, with speakers
- Neutral in emotion

Consulting

- Focus. Specific goal and objective.
- Focus on changing attitude - practice.
- Base on personal issues and needs.

Communication and health education

- Focus. Highly generality.
- Giving information, purely educational.
- Base on the need of the community.

Consulting process

- Create a bond with the client.
- Locate the need, objective and limit.
- Consult:
 - Provide all information,
 - Apply consulting skills to understand the issue,
 - *Keep the client's information secret,*
 - Understand the client and help him/her to take the best decision.

Communication and Support skills

- Listening and learning skills:
 - Using non-verbal communication effectively,
 - Use open-questions to get information,
 - Show respect,
 - Repeat the information, not the words
 - Sympathize, not criticize.
 - Encourage the client to speak the things which are "hard to speak".

Building trust and support

- Accept the client's thoughts and feeling – even if they're not correct,
- Assist the client to take decision by himself/herself,
- Support in action,
- Collect information, evaluate the situation, decide which kind of information to give,
- Comment the clients to have good ideas, to be able to talk about their ideas.

ACTION PLAN

- Consider all above conditions.
- Encourage the client to summarize the exchanged parts, give all possible solution, pick the most proper one for the client's current situation.
- Make the action plan with the client – avoid telling the client what to do or giving orders. *(It's crucial, as the fathers have to do themselves and will strongly affect the support for wives, children).*



Summarize of the consulting process

- **Welcoming:** Greeting, introduction
- **Questioning:** Economic, health, family status
- **Considerate:** attentive when giving the information,
- **Patience:** persist in explaining
- **Reassurance:** encourage the client to take necessary solutions
- **Benefit:** of go for 2nd check up, consulting: answer, explain the result, the next move...

→ **THÂN AI**

Summarize the consulting process

- **Meet up:** greeting, introduction
- **Ask question:** understand the need, expectation...
- **Introduction:** giving accurate information, signs of disadvantages or difficulties
- **Assist:** Help the client to understand the nature of the issues, giving suitable solutions
- **Explain:** any unclear topics
- **Meet again:** Check the result, send to higher

Thank
you for
listenin
g!

on maternal healthcare
mediate midwives
method



Training Workshop Power Point Presentations: Consulting Methods



ORGANIZE
HEALTH
COMMUNICATION

TRÌNH BÀY: CN.HS ĐẶNG THỊ NGHĨA

HEALTH EDUCATION - DISCUSSION

Is a process of impacts - with specific goal, objective, plan – to people, help to promote their knowledge to change attitude, accept and maintain good activities which are beneficial to the community and population.



Health education methods

Direct Communication – Health education

- Popular, direct communication, convenient.
- Quite effective, suitable solutions.

Methods:

- Talk in big groups, may intergrate in other programs
- Talk in small groups
- Individual health education
- Household health education



Health education method (2)

- **Indirect communication – health education**
- Provide knowledge for the community.
- Directed by the needs of the community.
- Give general solutions.

Through using means such as radio, newspapers, magazines, TV, flyers, leaflets, posters...

- Simple language, easy to understand.
- Easy-to-do methods.




CÓ THỂ BẠN CHƯA BIẾT?

LÀM THẾ NÀO ĐỂ THÀNH CÔNG TRONG CUỘC SỐNG

Mọi - ít đi
Thờ - vừa hơn
Quản lý - lịch sự
Làm việc - chăm chỉ
Cư xử - đúng đắn
Tâm hồn - đều đặn

Ăn uống - hợp lý
Ngủ - đầy đủ
Hành động - đúng đắn
Suy nghĩ - sáng tạo
Kiểm tra - lượng thực
Đã dành - thông minh.

COTHEBAN CHUABIET



Organize health discussion

- The most popular method for the community.
- Usually integrated with other activities.
- Hosts have great role in the success of the discussion.
- Other participants must support effectively.
- Use all resources, equipments, fund or call for donation.

What need to be prepared

- Identify the topics for the discussion
- Identify the audience
- Identify the contents
- Identify the time of the presentation
- Prepare the equipments
- Arrange the date and location.

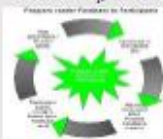


Implementation (1)

- Create a good relationship with the audiences
- Language must be clear, easy to understand, suit with the local culture and language (no jargons)
- Present the contents in order
- Use illustrations
- Observe the audiences, motivate them to participate in active discussion
- Observe the audiences in general to be able to adjust the presentation.

Implementation (2)

- Take time to answer the questions.
- Have Q&A times for each topics.
- Answer clearly and fully all questions.
- In case the questions are too difficult, may ask the people to answer another day, do not answer randomly



Conclude a discussion

- Check the attitude of the subjects
(ask some people about some points in the discussion).
- Summarize and emphasize the main contents, highlights of the discussions.
- Thanks people before finish.



Small group discussion

- Prepare: Same as "Health discussion"
- Add: Secretary to document things people mention
- Moderator: Motivate people to participate, give their own ideas
- Take note of things everyone agree on
- Moderator: remind people to do what agreed, set the time to do the job and finish time.



Household visit



Household visit

- Create a good relation with the household.
- Familiar environment: the members would feel ease, easy to take information, confident to talk about their opinions, views.
- Can see directly the current status of the family.
- Able to give actual advices.



Household visit

- Before visit: collect some information, ask for a proper appointment.
- During visit:
 - Starting by greeting, explain the purpose of the visit.
 - Quick observation, identify related issues, sick people...
 - Talk with each members or all, depend on the topic.



Household visit

- When finish
 - Summarize the highlights
 - Check the subjects' attitude on the discussed topics.
 - Create the environment to solve related issues, with proper time.

Thanks for the household's cooperation!



Prepare communication script

- Write in active voice, assertive.
- Simple language, easy to understand but attractive.
- Give actual, realistic advices which the audiences can do.
- Broadcast: ≤ 10 minutes.
- Discussion: ≤ 20 minutes.



"Thầy thuốc là người bảo vệ sinh mạng con người, sống chết trong tay mình nắm, họa phúc trong tay mình giữ. Thế thì đâu có thể kiến thức không đầy đủ, đức hạnh không tròn vẹn, tâm hồn không rộng lớn, hành động không thận trọng..."
(Hải Thượng Lân Ông)

CHÚC MỪNG NGÀY THẦY THUỐC VIỆT NAM 27-2

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- National manual on Reproductive Health, 2009.
- Health communication and education skills, 2005.
- Training manual for fathers... 19291.



*Thank you
for listenin*



Appendix C
Training Manual for CHWs

Hanoi School of Public Health, Brock University, St. Jerome's University

**HOW TO COUNSEL FATHERS TO BE INVOLVED IN BREASTFEEDING AND
INFANT DEVELOPMENT**

Manual for Health Workers

Father Involvement: Saving Brains in Vietnam (2014)

Contents

Part I: Father Involvement Principles	
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Part 1: Father Involvement Principles

The Benefits of Father Involvement

Children's relationships with significant people in their lives are extremely important for their development. Infants need to feel secure and loved in order to develop properly. Mothers tend to be the primary infant caregivers so that connection is of particular importance. However, the relationship of the infant with the father is also very important. Children who have a strong connection with their father have very good intellectual and emotional development. In addition, a positive, responsive, supportive relationship of the father with the mother helps the mother to have a better connection with the infant.

Research studies around the world (Lamb & Tamis-LeMonda, 2010; Allen & Daly, 2007) tell us that children of fathers who choose to be highly involved in their lives demonstrate:

- cognitive and intellectual benefits
 - greater ability to think and reason
 - stronger verbal skills
 - greater intelligence
 - more motivation and success in school
- emotional and mental health benefits
 - fewer emotional and behavioral problems
 - better emotional regulation
 - more internal locus of control
- social and interpersonal benefits
 - greater empathy
 - better social and problem-solving skills
 - less sex-stereotyped beliefs
 - greater overall life satisfaction

Of course, this involvement must be of good quality. If a father has a poor relationship with the mother or the child and there is much conflict in the family, the father can damage the child's development.

There are several ways that fathers can have this good quality involvement with their infants.

- A. Fathers need to be part of a team with mothers to jointly care for their infants
- B. Fathers need to spend time directly interacting with their infants
- C. Fathers need to be warm and caring with their infants
- D. Fathers need to pay attention, be sensitive to what their infant needs and respond in a way that is best for the infant
- E. Fathers need to touch their infants
- F. Fathers need to talk to their infants
- G. Fathers need to help their infants explore and learn in their own way and do things for themselves
- H. Fathers need to play with their infants
- I. Fathers need to use *gentle* control and correction as the infant develops
- J. Fathers need to protect their infants
- K. Fathers need to ensure that basic physical needs of the infant are met

A. The Teamwork Model

- Fathers and mothers can do the best job of caring for their infant if they work as a team. Even breastfeeding, which a mother must do, works better if the father and mother work as a team to make sure the mother can breastfeed successfully.
- Being a parenting team is sort of like being a beach volleyball team.
 - A father/mother team, like a beach volleyball team has only two people, so **each person is important** and **each must do his or her part**.
 - Unlike a 6-person volleyball team, in beach volleyball the players can't be specialists (i.e., spiker, setter, blocker), they must be **flexible and able to adapt** to whatever the

situation requires. Fathers cannot directly feed their infant, but when they are flexible and willing to do any other task around the home and with the infant, the mother has more time and energy to breastfeed as often and as much as the baby needs.

- A team is much more effective if players **do not try to duplicate each other's efforts** (e.g. both do not go up to spike at the same time). Helping with breastfeeding might include making a meal, bringing a drink and a snack, or caring for an older child so that the mother can breastfeed. Every father will have his *own unique way* to give that help. Fathers can have a special infant care task that they always do, such as giving the baby a bath or getting the baby ready for nighttime.
- Team members need to **communicate with each other**, both verbally and non-verbally. It is *very* important for mothers and fathers to talk to each other about what they are thinking and what they want and need. Each couple should talk about possible ways that the father could help the mother who is breastfeeding. They should also discuss what the father will do to care for and interact with the baby. Each couple and each father will make their *own* unique decisions. Making decisions together is more likely to make both the mother *and* the father feel happy. Watching facial expressions and body postures for signs of agreement or disagreement, happiness or sadness, comfort or discomfort is also very important.
- When a task involves both players (e.g. a double block) the players **coordinate their efforts** (e.g. they cut off different angles). When the mother needs direct help from the father (e.g., she is have a problem with breastfeeding positioning or latch or she is making a decision about whether to give formula milk before 6 months), the father needs to communicate with the mother and work together with her to give her the help that she wants and needs.
- Players need to be **attentive** to each other and **sensitive** to cues so that they can respond to changes (e.g. a feigned spike). Mothers appreciate when they get the support they need without even asking. When a father is sensitive to the mother and pays attention to what she is doing, he learns how much and what kind of help she wants. Every mother is a little different.
- Each player must **trust** the other to get the required job done and each must **give the other the space they need** – however, they also need to be ready to **step in and assist** if something does not go according to plan (e.g. if the other player has slipped or is down

from a dive, buy time by setting the ball higher or bump the ball over the net if it looks like the other player cannot get up quickly enough), but only do so when necessary.

- Players **encourage** each other and **affirm** and **comfort** each other when there is a mistake made. Fathers need to encourage, affirm and comfort the mother if she makes a breastfeeding “mistake” (e.g., she is having difficulty sticking to her decision not to feed formula milk to the baby). Fathers also need to realize that they might not always provide the kind of help the mother needs. If the mother seems unhappy, the father should gently find out what he could do differently so that he can feel encouraged by the mother to continue his important roles in the breastfeeding and parenting team.

B. Father-Infant Time

- A father can only develop a good relationship with his infant by directly interacting with his infant. A father can hold and play with his baby. He can change diapers, bathe the baby or dress the baby. He can take his baby for walks in the yard, to the shops, or to visit friends or family members. He can have his baby beside him while he sits watching the television. The father should talk to the mother about what activities he would like to do with the baby.
- The more time the father is able to spend with the baby, the more the baby feels loved by the father. When a father spends time with his baby, he gets to know what the baby wants and needs. He soon can tell whether the baby wants active play or needs to be cuddled, needs to eat or rest, needs to be carried or to lay quietly in bed, wants a song or needs to burp. A father who spends time with his baby learns what his baby’s crying means.

C. Warmth and Caring

- A young infant is a person – a small person with a lot of growing and developing to do, but still a person with unique characteristics and “personality”. You do not need to wait until children are older to form warm, caring relationships with them.
- A father must be gentle with his baby. When a father holds his baby in his big and strong arms, the baby feels secure. When babies get older, they enjoy fun play with fathers. A father needs to help comfort a baby who is upset. He can cuddle and talk to a crying baby. If the father feels sad because his baby is upset, he can talk to the mother or to another father about how he is feeling. A father who can share his emotions creates a happier, more caring home for his baby.

D. Attention and Responsiveness

- In all the things that a father does with his baby, it is important for him to follow his baby's cues. A father needs to pay attention and be sensitive to what his infant needs and respond in a way that is best for the infant. The more time a father spends with his infant, the more he understands his baby and can respond effectively.
- Interacting with an infant is easy. Let the baby take the lead and you follow. Watch and listen to see what the baby does and then do something back. For example, a father can imitate his baby's sounds, actions, or facial expressions. He should then wait awhile and see if his baby tries to make a face, sound, or action in response – how did his baby respond to what he did? His baby may like what he did and show approval, or his baby might change the direction of the play. Keep watching and respond back in a kind of “conversation”. A father can talk to his baby, describing what the baby is doing and can encourage his baby by smiling, clapping, or cuddling.
- It is important to remember to pay attention to when the baby wants to stop. Even a newborn can show this by turning his head away, closing his eyes, or crying. Older babies can show they are ready to stop by their facial expression, body movements, or the types of sounds that they make.

E. Touch

- A father can show his baby love by touch and sound. Physically caring for the baby, holding the baby, stroking, tickling, and gentle movement show care through touch.
- Skin to skin touch, such as sleeping on a father's chest is a great way to touch a baby. A baby who experiences caring touch learns to cope with physical and emotional stress. The body and the brain develop better.
- Baby massage and baby aerobics are enjoyable ways to touch babies. Lay the baby down on a safe surface. Get close to the baby. For baby massage, gently stroke the baby's arms, legs, head and body. To do baby aerobics, gently bring the baby's arms into the chest and then spread out to the sides. Gently bend the baby's legs up and down. Talk or sing to the baby. Repeat the actions several times, as long as the baby is enjoying the game.

F. Talk

- Every father can talk to his baby, using loving, caring words. Babies love the sound of singing and don't care if the father sings well! Talk and singing stimulates a baby's brain and helps babies to learn about the sounds that they will imitate in order to talk. A father should pay attention to how his baby tries to imitate the sounds that the father makes as he talks or reads.
- Fathers can read to young infants. Although they may not understand what a father is saying, the baby will enjoy the sound of the father's voice and it is a nice close, cozy time together. When a father changes the sound of his voice or make funny noises while reading, it is fun for baby and the father, and it helps the baby learn new and different sounds.

G. Exploring and Learning

- Each baby has his own way of learning. It is important for babies to be able to do things for themselves. A great way to teach a baby is to do something that the baby shows interest in doing. A father does not always need to be actively playing with his baby. Sometimes a baby is happy to play on its own beside the father. Fathers can start learning games and activities with their babies, but should also watch the baby to discover the ways the baby likes to learn. Babies need to be able to try out new actions, even if they can't do it correctly. Trying again is the beginning of babies learning how to solve problems.
- A father can help his baby learn by exploring his surroundings. New babies learn by looking at faces and interesting objects. A father can hold a household object or toy in front of his baby, move the object around slowly, and talk about the object. A father can carry his baby around and show him the house and the yard, talking about what he sees. It is important to pay attention to what is interesting to the baby. That will tell a father what a baby will enjoy doing again. Repeating activities helps babies learn.
- For a baby any interesting object can be a toy – a ball, a stuffed animal, a cloth, or a colorful plastic cup.
- A father can dangle interesting objects over his baby when the baby begins reaching, so the baby can kick or bat at the object.
- Babies like to hold onto things—fingers, hair, blankets, toys, and anything they can touch. Babies also put everything they hold into their mouths. Babies explore and learn about things when they suck and chew on things. Fathers can give the safe baby objects to hold and explore with their mouths.

- Babies like to look at books and listen to fathers read. As the baby grows, the father can play games like peek-a-boo, rolling a ball, hiding a toy, stacking toys, tickling games, splashing in the bath, etc. It is helpful for a father to know the progression of skills that a baby learns so the father can try something new with his baby that is not too difficult.
- The baby needs to experience different ways of using his body. A father can get down on the floor and play with his baby when the baby is on his tummy. A father can hold his baby in a sitting position, with as much support as the baby needs. Putting toys a little out of reach of a baby who is beginning to roll to the side will encourage movement.

H. Play

- Play is fun and interesting and it helps babies learn. Play tells babies that their fathers like to be with them. Fathers can play when doing day-to-day care of their babies. Fathers are often good at active play with their babies.
- Fathers can take on different kinds of roles when they play (Father Involvement Initiative—Ontario Network, 2005). Sometimes a father can play by having his baby nearby and watching his baby play. A baby loves it when the father cheers when the baby does something new or fun.
- A father can be an entertainer when he reads makes faces, tells a story, plays with a stuffed toy or a puppet with a silly voice, stacks up blocks, plays peek-a-boo, or hides and “finds” a toy. A father with a young baby can hold the baby up to a mirror and ask, “Who’s that baby?” He can make funny faces, like sticking out his tongue and wiggling it. The father should watch whether his baby tries to imitate the face. A father should also pay attention to which sounds make the baby turn his head or how the baby reacts when the father wiggles his toes or gently bicycle his legs.
- Sometimes a father is a teacher, helping his baby learn a new skill like fitting a nesting toy together. A good teacher allows his baby to try the skill and helps just enough so the baby gets the idea of what to do but does not play with the toy for his baby.

I. Correction and *Gentle Control*

- When you truly care for someone, you want what is best for that person. When it comes to babies, this means that you will sometimes need to direct a baby’s actions so that your baby

can learn appropriate behavior or in order to prevent the baby from doing something harmful.

- It is important to remember that young babies are not deliberately trying to be naughty or disobedient – it takes a long time to learn what is correct and safe – a father may have to redirect behavior many times before a child learns.
- When a father needs to redirect, it is important to use gentle control and to be careful not to harm or injure the baby. Harsh, painful, anger-driven punishment is detrimental to children's well being.
- In order to redirect your baby, a father can give the baby something else to pay attention to. He might give the baby a different toy, talk or making distract sounds, or draw attention to himself (e.g., make a face). It helps to reward the baby for changing the focus or stopping the non-desired behavior (e.g. hug the baby, say something friendly)
- As his baby develops and grows older, a father needs to use effective guidance and discipline so his child feels loved and accepted. It is important for a child to understand why they are being disciplined (e.g., "I am stopping you because hitting other children is not good. You need to be nice to other people. If you hurt other people they will not like what you are doing and they may even hurt you back."). By explaining why discipline is taking place, parents provide opportunities for the child to learn something beneficial (e.g., socially appropriate behavior) and children will come to regard such disciplinary guidance as a sign of caring.

J. Protection

- Keeping his family safe and healthy will always be an important part of a father's job.
- Fathers need to work together with the mother to create a safe and clean environment. Babies explore everything with their mouths, so anything that a baby holds must be clean and non-toxic. Also, it must be too big to choke on, have no sharp edges, and there should be nothing that the baby can pull off and swallow or choke on.
- Fathers need to learn to hold a baby safely. They should not roughly shake a baby, either in fun play or in anger – it can damage the baby's brain.
- When a father is caring for his infant—even a new infant—he should always keep one hand on his baby, so he knows the baby is not going to fall. He should allow anyone to leave the baby unattended in a place where the baby could fall or get trapped.

- Fathers can be involved with their infants by taking the baby for health visits and vaccinations. Even if the father is not able to go to the health visit, he can be involved by talking to the mother about his baby's health and helping care for a baby who is uncomfortable following a vaccination.

K. Meet Basic Physical Needs

- Throughout history, fathers have played an important role in providing basic physical needs for the family (e.g., food, shelter, and clothing). This will always be a way that fathers take care of their babies. Fathers need to work together with the mother to ensure that the basic physical needs of the infant are met.

Basic Principles

Although the amount of information listed above can seem overwhelming, the basic principles are very simple. In order to thrive, children need a father who:

- a) takes time to develop and nurture warm, caring, trusting, and respectful relationships with his wife and child
- b) communicates with his wife to find a unique, couple-specific way in which the two of them can work together as a parenting team
- c) is attentive and sensitive to what his wife and child need and responds in ways that are best for mother and child

If fathers can learn and use these principles, the child will benefit.

Reflection Questions

Every father is different and will interact with his child in a unique way.

Here are some questions for fathers to help guide them in thinking through what kind of fathers they want to be (adapted from Father Involvement Toolkit, p. 44).

- What was your reaction when you learned you would be a father?
- How does your relationship with your father affect your relationship with your children?
- Do you believe the father role has changed since your father's time?
- Is your role as father valued and given worth in your circles (family, friends, workplace)?
- What stands in the way of your having an ideal experience of fatherhood?

- In your work environment
 - In your social life
 - In your commune
 - In your family
 - In you, personally
- How does Vietnamese society's values affect your ability to have an ideal experience of fatherhood?
 - When you have doubts or worries in relation to your role as a father, who can you count on (family, friends, services, others)?
 - How could we reach men and fathers more effectively?

It is also extremely important to have a community and organizational culture that welcomes fathers and makes them feel valued and included – the commune health center needs to include fathers in visits, good to have written material, posters, etc. that include father. Even if fathers want to be involved with their infants, they may resist doing so if their families, peers, and community are not supportive. However, if family members, peers, and people in the community are supportive of father involvement, even ambivalent fathers may feel inspired to try to connect more with their infant.

Resources

St John, Cameron, & McVeigh (2005)

Capuozzo, Sheppard, & Uba (2010)

www.babycenter.com

www.zerotothree.org

"My Dad Matters Because... Fatherhood Toolkit"

Hoffman (2011)

"Daddy...Come Play With Me"

Magill et al. (2007)

Dad Central retrieved from http://dadcentral.ca/new_dads

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Part II: Counseling for large group

I. Counseling for large group

Objective: After the training, participants will be able to:

1. Understand the importance of counseling for large group in improving knowledge for community.
2. Organize counseling session for large group in community

Contents:

1.1. Definition of counseling for large group: A form of providing information to a target group (15-30 people), which is commonly used in communication, education and health. This is the process of exchanging and sharing information, knowledge in order to change attitudes and behaviors of individuals, groups of people and communities and thus create activities, practice for improving health for those individuals, groups and communities.

1.2. Preparation for large group counseling.

- 1) Clearly identify the theme of the counseling: this helps the counselor prepare contents of the counseling. For example, talking to a group of about 20 husbands who are preparing for their wives to breastfeed their babies after birth.
- 2) Clearly identify target audience of the counseling: Husbands of pregnant women.
- 3) Organise the order of contents to be presented in the counseling.
- 4) Identify time for counseling and time range of each content
- 5) Recruit fathers for group counseling. In this particular case, it is counseling for group of husbands who bring their wives to have antenatal care on 21th day of each month and thus appointment should be made to ensure the number of participants

1.3. Steps of counseling for large group:

- 1) Greet everyone, introduce yourself and present clearly the purposes of the counseling session.
- 2) Encourage everyone to actively participate in the discussion during counseling.

- 3) When you ask a question, make sure that you wait for fathers to answer and give their ideas.
- 4) Use clear, understandable words which are appropriate with custom.
- 5) Present contents prepared.

For example:

- *Preparing delivery place: Health commune center, district hospital,*
- *Prepare necessary things for the child and the mother*
- *Encourage the mother in pregnancy period*
- *Ask the grandmother to help the mothers in breastfeeding*
- *Encourage their wives during pregnancy period and delivery in order to help them in breastfeeding.*

- 6) Observe to adjust forms of presentation if needed
- 7) Spend time for participants to ask and discuss unclear issues after each content
- 8) Explain clearly all questions of the audience. With difficult questions, that you can not answer immediately, promise to answer at another time, do not give wrong answers.
- 9) At the end of counseling session, it is necessary to check if the audience understands the contents by asking questions.
- 10) In summary, emphasize main contents for themes to remember.

II. Plan of providing group counseling

Counseling for large group /topic talks at commune health centers

- **Counselor:** Head of commune health center
- **Client:** group of husbands (2 – 20 persons)
- **Counseling time:** in the morning on 21st day monthly (counseling could be arranged at a different time on another day if needed to accommodate the schedules of the fathers, e.g., if working away from the community and cannot come in the morning)
- **Counseling contents:** prenatal counseling (or according to the audience)
- **Preparation** for organization of counseling for large group:
 - From 14th to 17th every month: send invitation, give announcement to couples on prenatal check-up and group counseling in the morning of 21th of the month. In the

invitation, emphasize that the appearance of the husbands for prenatal check-up is essential and clearly stated check-up time. Because all pregnant women are in the commune, they can be divided into groups for prenatal check-up and counseling and check-up time for each woman has to be stated in the invitation. There should be 10 men in each group. For instance, there are 20 – 30 pregnant women in the commune, the group division for counseling is made as follows:

Group 1: sending 10 – 15 invitations indicating that prenatal check-up will start from 8.00am. The first group will be provided with group counseling from 8.20am to 9.20am.

Group 2: sending 10 – 15 invitations indicating that prenatal check-up will start from 9.30am. The second group will be provided with group counseling from 9.30am to 10.30am.

→ Then in the morning of 21st of the month, two groups of husbands will be provided with group counseling.

- On 20th day of month, prepare and arrange the counseling corner (Nutrition counseling corner), including tables, chairs, tea, water, and materials (leaflets, handbooks if available).
- In the morning of 21st day of month, the midwife provides prenatal check-up for pregnant women, the head of the commune health center takes responsibility of providing group counseling for the husbands. There should be 2 to 10 husbands in each group.
- *Note: When providing counseling for large groups of husbands, the counselor has to fill in the group counseling diary.*

I. Counseling contents for Father involved in Breastfeeding

Begin by encouraging open discussion with fathers.

- You are soon going to be fathers. What does it mean to be a father? What are your hopes and dreams for your new baby? What do you hope your baby will be like in 20 years? What will your role as a father be?

- Fathers love their babies and want them to be healthy, happy, and smart. As a father, you can make your baby healthier, happier, and smarter. Studies from around the world have shown that babies grow up to be smarter, healthier, and better able to get along with other people when they have fathers who care about them and get involved in their lives. Fathers matter a lot and they are important for both boys and girls.
- Babies know when someone cares for them and wants to be with them. Even if you can't be with your baby a lot, spend time taking care of your baby and playing with him or her when you do get the chance – your baby will notice.
- There are some very important things that fathers can do. First, fathers can work together with the mother to raise their child. This means working together as a team.
- Think about what it is like to play on a team with two people like badminton or beach volleyball. First, each person is important and each person must do his or her part. You may be better at some things and your partner may be better at other things but both of you have to be able to do whatever is needed. Second, you can't take over for your partner or always try to do the same thing as your partner. You have to trust your partner to do what is needed. You stay out of the way and let your partner do what is needed and you only step in and take over if your partner is in trouble and needs help. Third, you and your partner have to talk to each other. Both of you have to know what you are going to do and you have to pay attention to each other. You praise and encourage each other when things are done well and you comfort and support each other when someone makes a mistake.
- All these things are important when you and your wife are working together as a parenting team.
- One important way to make sure a baby is physically healthy and grows well is to work with your wife so that she is healthy in her pregnancy. Talk to your wife about how you might be able to help her, e.g., doing hard work for her; helping her be more comfortable, or giving her a gentle back massage if she has a sore back.
- Ask if she has any worries about the birth, breastfeeding or being a mother. If you are working away from home, you should call home or come back home more often so your wife knows she can count on you to support her.
- Discuss with your wife about having sex—she might feel too tired or uncomfortable sometimes. Let her know you understand if she does not want sex as often.

- Take your wife for prenatal check-ups before giving birth (ideally every month in the last three months). Check if she has vaccinated against tetanus. If she has not, she needs additional injection at least one month before the expected date of delivery.
- Prepare for the delivery: discuss together to choose maternity hospital. Be with your wife during the delivery.
- Another important way to make sure your baby is healthy and grows well is to work as a team so that your wife can breastfeed well.

Breastfeeding is the natural feeding method from thousands of years associated with the birth and survival of humanity. Breast milk is the best source of nutrition to ensure the survival and development of children that can not be replaced by any other food. Practical experience and results of many studies have confirmed the very important role of breastfeeding in early years of life based on the following benefits:

1. Breast milk is the best and perfect food for infants as it has all necessary nutrients that they need. Breast milk also contains substances to prevent children from infectious diseases. Breast milk is the food source that is always fresh, clean and always available for the child at her mother's breast, you do not need to buy and do not take time to prepare. With infants, in the first six months of life, breastfeeding brings them all needed nutrients for development. They do not need any additional food or any other drinks, not even water.
2. Most mothers produce a special milk right after birth. This milk is called colostrum and exists only a few days after birth. Colostrum is not much but enough to meet both the quantity and appropriate nutrients for newborns. In particular, colostrum contains extra anti-infective factors that help to protect infants from infectious diseases in the early stage of life – when they just moved from a warm safe environment in the womb to the outside environment with high risk of infectious diseases. Moreover, these anti-infective factors continue to contribute to the formation and complete the immune system of the child. Therefore we considered breast milk as the first dose of vaccine to protect an infant to against diseases.
3. Thirdly, breast milk makes a good brain development, improves the nervous system, creates the optimal platform for the development of children's intelligence.

With the above benefits, breastfeeding is the critical factor for:

1. Healthier children with better resistance capacity to infectious diseases, which helps to reduce child morbidity and mortality. Many studies show that improved breastfeeding alone could save 3,500 children every day worldwide, and it is the most effective intervention among all other preventive interventions for child survival.
2. Children with appropriate weight and height development. This helps to reduce the rate of malnutrition among children as well as the risk of being overweight and obesity in their first two years of life since breast milk has a hormone that protects children from excessive weight gain.

One another important benefit of breastfeeding is to protect mothers' health:

1. If mother breast-feeds immediately after giving birth, it helps mother's uterus contract better and that reduces the risk of bleeding.
2. Mother who breastfeeds have less risk of breast cancer, ovarian cancer, osteoporosis than non-breastfeeding mothers.
3. By breastfeeding her infant, a mother's metabolic efficiency is enhanced, which allows her to make better use of the food she consumes.
4. Exclusive breast-feeding at least for the first six months will help mothers to slow down the time their periods come back, thus breastfeeding can be considered as a natural contraceptive method.

Breastfeeding also brings practical benefits to the community:

1. Environmental protection: Breastfeeding is a highly appreciated environmental protection activity as breast milk is a natural food, it does not require fuel costs for processing, transporting; no need to package; no need for land to build factories ... thus it does not produce any waste which may pollute the environment.

In summary, breastfeeding is the best practice of all mothers in the world, especially in the first six months after birth. They all, without any border, can breastfeed their children, regardless of language, wealth and social status. This is a safe and convenient child feeding method. Mothers can breastfeed anytime and anywhere which is convenient for them. It increases the bonding between mother and child while reduces mother's stress and anxiety.

In order to work as together with your wife so she can breastfeed successfully:

1. You should encourage your wife to hold the baby as soon as possible and as much as possible.
2. Remind her to breastfeed the baby as soon as possible, ideally within the first hour after giving birth.
3. Do NOT buy formula milk for baby your wife's breastmilk can supply baby's demand.
4. Do NOT give any other food or liquid to the baby in the first days. Let your baby drink your wife's very special colostrum milk.
5. Encourage your wife to breastfeed exclusively for six months. Your baby should only receive breast milk without any additional food or drink.

A third way for a father to ensure that he has a happy, healthy, smart baby is to build their own relationship with their baby.

- Babies are unique, special people.
- What kinds of things will you be able to do with your brand new baby? (e.g., holding and cuddling baby, talking to baby, changing diapers, bathing) Any of these are good ideas. Every family is different, so what each of you does with your baby will be different.
- Talk to your wife about how you will be a team to take care of the baby together. Talk about the ways you would like to interact with your baby.
- When you work together, you will give your baby what is needed to be healthy, happy, and smart.

IV. Documents used in counseling for large group

- Training materials
- Flyers and posters
- Practical experiences

V. Guidelines for Informal Group Counselling

Objective: Reinforcement of information provided in individual and large group counselling Solve problems and provide new information on BF and infant development.

Suggest father's doable actions.

Provide fathers with opportunity to share information with other fathers.

- **Counselor:** Any available trained commune health worker
- **Client:** group of husbands (2 or more persons)
- **Counseling time:** when 2 or more fathers are together at commune health center; brief time (e.g., 5 to 15 minutes)
- **Counseling contents:** according to the audience

When fathers are at the commune health center, counselors should ask them if they have any questions or concerns about the wife's breastfeeding and about caring for and playing with their infant. If there are two or more fathers, ask if they are interested in talking together about caring for their babies. Answer the fathers' questions and reinforce information about breastfeeding and father-infant interaction. Encourage the fathers to share with each other about what they are doing with their babies and to share with each other their ideas about how to address fathers' questions and concerns. Part III: Individual father counseling

I. Counseling skills and assistance

Father involvement counseling is a process in which a healthcare worker assists a father in supporting breastfeeding and assisting the mother in solving potential difficulties and encourages direct father-infant interaction. The counseling is based on the infants' age and current situation of the mother, as well as the husband's knowledge and reported behaviors.

Healthcare workers should learn and practice well in order to:

Gain good communication and assistance skills:

- Listen and learn
- Build trust and be ready to assist.

Solve problems and strengthen practice:

- Encourage the husbands work together with their wives to practice breastfeeding properly

- Assist fathers to support mothers who have troubles with breastfeeding or practice improperly
- Encourage fathers to interact with their children.
- Counsel fathers about maternal child health, nutrition and family planning
- If unable to jointly solve a problem with the father, obtain advice or transfer to an appropriate healthcare worker

1. *Gain good communication and assistance skills:*

In order to conduct an effective counseling, the counselor needs to have good communication skills. These skills will help solving various cases, not only in breastfeeding counseling but also family planning counseling or counseling on other aspects of daily life. The summary below is for breastfeeding counselors; however it can be used for counseling on other topics

There are two groups of basic skills:

1.1. *Listen and learn* encourage the father to talk about his situation and thoughts. This skill helps the healthcare workers listen and understand what the fathers say.

- Body Language: Gesture, appearance, facial expression of the healthcare workers would show how they respect and pay attention to what the fathers say. Do not sit (or stand) higher than fathers; sit or stand equally, use eyes-contact, nod your head and smile while listening. Do not show that you are in a rush or lack of time; interacting with the fathers, mothers, or the infants requires compliance with local customs and privacy.
- Use open questions: usually use “how”, “when”, “who”, “what”, “why”, etc., which are capable of retrieving much information while making the conversation easier. In contrast, close questions with “yes” or “no” answers are usually used to confirm information.
- Show respect and use gesture which indicate that you are listening: using the expressions “really?”, “Ohm” , “tell me more about,” “your child is so good”, etc.,
- Repeating the main message of what the clients say in your own words is useful as it shows that you are listening, and thus encourage the clients to talk more. You should use synonyms and not repeat exactly what the clients say. It is possible to just repeat few key words.

- Show sympathy, which indicate the healthcare workers understand the clients, their circumstances, their feelings; it is possible to use phrases such as: “this is quite difficult, isn’t it?”, “I can see that you are worried”
- Ask questions to get more information, such as “is your baby fretful at night?”
- Avoid judgmental phrases such as “right”, “wrong”, “good”, “not good enough”

1.2. ***Skills on building trust and being ready to assist*** helps to deliver information to fathers, encourage fathers to practice in their circumstance and supports them in making the best decision. Assisting support to the fathers to make their own decision is better than giving instructions, and advice that sometimes the fathers do not listen and follow, or even feel uncomfortable to meet the healthcare workers again.

- Accept the fathers’ opinions and feelings. This does not mean an agreement with the fathers’ inappropriate opinions and actions. If needed, the healthcare workers will modify to deliver correct information while respecting the father’s understanding, e.g., “I understand that you think..., Many new parents believe that and ... is good. However, now we know that....”
- Recognize and encourage fathers who work together with their wives as a team to support each other and practice breastfeeding properly. Recognition and encouragement for good practice will help couples build self-confidence. After encouraging good practice, try to modify wrong practice. The healthcare workers should also encourage the child for his/her growing up.
- Ask fathers for their ideas about how to solve a problem. Add healthcare worker suggestions to those ideas with.
- Practical assistance is always better than mere words. Helping the father with normally simple behaviors such as putting the child onto the mother’s chest, or making a comfortable seat or bed for the mother are very useful. Assistance in breastfeeding is practical assistance, along with information delivery. The fathers are more willing to receive practical assistance than mere information.
- Have fathers work together with mothers to try out recommended behaviours whenever possible.
- After listening to the fathers, the healthcare workers need to evaluate the fathers’ current situation in order to determine the most appropriate information. Avoid talking too much because that might confuse the fathers or make them forget the previous information.

Sometimes, discussing what the fathers already knew is more effective than immediately telling the husband what to do, i.e. what is “the milk comes in”, or why the husband’s assistance has good influence on milk production.

- Using simple language is important as fathers will understand the information easier in the forms of casual language, not terminology.
- Have fathers summarize what has been discussed and what they plan to do. This will check their understanding and reinforce learning.
- Give suggestions, not orders. If the healthcare workers tell the fathers what they must do, it is unsure if the fathers really do it even when they do not disagree. Some receive appointment date but never come. The health care workers should give suggestions and discuss possible solutions, encourage the fathers to propose multiple methods then choose the one that is easiest to do. This is extremely important in raising infants and small kids as there are always many choice/methods to choose.

II. Plan of providing individual counseling

1. *Individual counseling at home visit (or in commune health center if father is not available at home)*

- **Counselor:** Village healthcare workers
- **Client:** the husbands
- **Time for counseling:** 4 times of counseling, including once in prenatal period and 3 times in postnatal period.
 - i) ***First time:*** 32th – 34th weeks of gestation. The counselor may know when the wife is in 32th week of gestation because the list of clients includes information on the last menstruation date of the wife. During the period from 32th to 34th week of gestation, the counselor makes an appointment with the husband via telephone or directly at household for counseling.
 - ii) ***Second time:*** Within 7 days after the wife giving birth. After giving individual counseling for the husband during giving birth period in medical facilities (hospital or commune health center), the midwife has to call and inform the village healthcare worker. Then the village healthcare worker visits the mother and her infant to provide counseling for the husband within 7 days (The list of participants in the

training includes names and phone numbers of midwives in communes and village healthcare workers)

iii) **Third time:** On 42th postnatal day. With date of birth informed by the midwife, the village healthcare worker can arrange to visit the fathers and his baby at household and give counseling to the husband on the 42th postnatal day.

iv) **Fourth time:** When the baby is 3 to 3.5 month old, the village healthcare worker visits the household and counsel the husband for the last time.

- **Counseling contents:** In each development stage of foetus/infants, counselor should provide counseling content mentioned in the table of “Counseling contents for Father involving in Breastfeeding” in part III below.
- **Note:** *When providing individual counseling at household, the counselor has to fill in the individual counseling diary on breastfeeding and monitoring notebook of village healthcare worker.*

2. Individual counseling at commune health center:

- **Counselor:** midwife or chief of communal health clinics
- **Client:** the husbands
- **Counseling time:** Whenever a husband (included in the list of clients for counseling on breastfeeding) comes to the commune health center and need counseling, information on taking care of pregnant women or breastfeeding, the counselor will provide him with individual counseling at the “Nutrition counseling corner” in the commune health center.
- **Counseling contents:** identify the gestation stage / week of the pregnant wife or the age of the baby to provide proper counseling information based on the table of “Counseling contents for Father involving in Breastfeeding” in part III below.
- **Note:** *When providing the husband with individual counseling at commune health center, the counselor has to fill in the individual counseling diary on breastfeeding.*

3. Individual counseling during giving birth at health facilities:

- **Counselor:** Midwives in health facilities (Kim Thanh district hospital or commune health centers). Midwives had to attend the training on “Counseling for husbands on supporting their wives in breastfeeding”.
 - In case of delivery at commune health centers: counselor can be chief of commune health center or midwife performing the delivery.

- In case of delivery at Kim Thanh district hospital: counselor can be midwife performing the delivery who participated in the training on “Counseling for husbands on supporting their wives in breastfeeding”. Counselor only provide individual counseling on supporting breastfeeding for husbands from 10 communes of study. Counselor has the list of project beneficiaries (approximately 400 couples) to identify the clients.
- **Client:** the husbands
- **Counseling time:** while the wives are in health facilities for delivery (before or after the wives begin labor in health facilities, as soon as possible after birth, and a session with father and baby before the wives are discharged to come home).
- **Counseling contents:** (see the table of “Counseling contents for Father involving in Breastfeeding”)
 - Session with infant, father, and mother helping father to learn about newborn capabilities.
- **Notes:**
 - *If the husband is absent in health facilities when his wife stays there, the midwife may not provide others with counseling but she still takes responsibilities for supporting the mother to breastfeed her baby within the first hour after giving birth.*
 - *When providing the husband with individual counseling in health facilities, the counselor has to fill in the individual counseling diary on breastfeeding.*

III. Counseling contents for Father Involvement

<i>Period</i>	<i>Counseling contents suitable for mother's and child's characteristics</i>	<i>Things father should do</i>
Before birth (32nd week of pregnancy)	<ul style="list-style-type: none"> • Final trimester of pregnancy, baby grows faster and has more movements. • Mother gains more weight and feels more tired, lies and sleeps harder as the baby moves more often. • There may be some signs of blockage including oedema, varicose veins of the legs ... If you see unusual signs as follow, you should go immediately to see doctors: vaginal bleeding, face and hand oedema, has fewer urination, headache, nauseating, your baby has fewer movements than usual or even no movements. • Signs of labor: contractions come at regular intervals and get closer together, water breaking 	<ul style="list-style-type: none"> • Talk to your wife about how you might be able to help her, e.g., doing hard work for her; helping her be more comfortable, gentle back massage if she has a sore back. • Ask if she has any worries about the birth, breastfeeding or being a mother. • Talk to your wife about how you will take care of the baby together. Talk about the ways you would like to interact with your baby (e.g., holding and cuddling baby, talking to baby). • If you are working away from home, you should call home or come back home more often. • Should not take your wife out far from home in this period. • Take your wife to do prenatal check-ups before giving birth (ideally every month in the last three months). Check if she has vaccinated against tetanus. If she has not, she needs additional injection at least one month before the expected date of delivery. • Encourage your wife to have a balanced diet to gain enough nutrients so that she can have lots of milk for breastfeeding later. • Prepare for the delivery: Be with your wife during the delivery, discuss together to

		<p>choose maternity hospital, remind her to breastfeed the baby as soon as possible, ideally within the first hour after giving birth.</p> <ul style="list-style-type: none"> • After birth, encourage and help your wife to breastfeed as nursing by the baby. This will impulse milk production. Even though milk coming after birth, which is called colostrum, is little, it still has enough nutrients for newborn. • Even if you baby is delivered by ceasarean delivery it is very important that your baby gets the colostrum right after birth. The anaesthetic medication cannot harm the baby and it is very safe for the baby to get the colostrum from the breast right after the birth. • If your wife gives birth by ceasarean delivery, your help will be very important. Help your wife find the most comfortable position to breastfeed. • Even if your wife is sleepy, you can help put the baby on your wife's chest (skin to skin) and help the baby to breastfeed. • Do not buy formula milk for baby as mother can supply baby's demand • Discuss with your wife about having sex—she might feel too tired or uncomfortable sometimes. Let her know you understand if she does not want sex as often; if your wife had a history of miscarriage or premature delivery, should abstain completely from sex in the last 3 months
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Right after birth (for midwives at hospitals or health centers)	<ul style="list-style-type: none"> • May be tired after delivering but happy as she now has a healthy baby. • Mother can be suffered from uterus contractions or from interventions during delivery. • Some mothers may feel sad because they did not have a son or a daughter as expected • In most cases, the babies are born in good health and they can nurse within one hour after birth. They should be kept warm, lie with their mothers and need to be protected when they first contact with the outside environment which is extremely different from the environment in their mothers' uterus. • Just few babies are born prematurely or suffered from asphyxia during delivery. These babies need special care. • Newborn infants can focus about 30 cm away, like to look at faces and eyes, can imitate 	<ul style="list-style-type: none"> • Help your wife to breastfeed as soon as possible within the first hour after giving birth. • If breast milk has not come yet or come with limited quantity, you should keep encouraging and helping your wife to breastfeed as nursing by the baby will impulse milk production. Even milk coming after birth, which is called colostrum, is little, it still has enough nutrients for newborn. • Do not buy formula milk to feed the baby. • Do not feed baby any extra food and drink except breast milk. • Try to let the baby stay with his mother as soon as possible, ideally let the baby lie on his mother's chest skin to skin. • Listen to your wife if she worries. Help her think about how to solve problems or reduce worries. • Encourage her to have a balanced diet to have enough milk for your baby. • If your wife hurts much, has any difficulties in breastfeeding or has any health problems after her delivery, ask doctors immediately. • Give father the personalized Father-Infant Relationship Calendar and explain purpose (See Calendar Guidelines) • Your baby can imitate your face, but you need to have patience—it might take a minute. Try it. • Your baby can hold your finger. Try it.
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	<p>facial expressions like sticking out the tongue</p> <ul style="list-style-type: none">• Babies have reflexes such as finger and toe grasp, walking movements if feet are touched.	<ul style="list-style-type: none">• Your baby will move his legs when you touch his feet. Try it.• Your baby talks to you by making little noises and by crying. You will learn what your baby's cries are telling you.• Your baby likes to be touched, cuddled, and talked to.• Show the dad a napkin to see what the meconium and urine look like.
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<p>After birth (during the first seven days)</p>	<ul style="list-style-type: none"> • The mother and child's health relates to the delivery. • Mother can be suffered from vaginal bleeding, stomachache, perinea pain, tiredness, headache or dizzy. • Having some difficulties while breastfeeding: having swollen breasts, painful nipples, abscessed breast or have little milk. • Baby: in this period, baby has to face with many risks for his health, such as: low body temperature, low blood sugar, being infected and some special neonatal problems as umbilicus bleeding, jaundice, skin or eye infection • Baby may have the phenomenon of "physiological weight loss" 	<ul style="list-style-type: none"> • Create favorable conditions for your wife to take adequate rest and diet as well as avoid stress. • Help your wife to breastfeed. If your baby sleeps much, remind your wife to wake him up to nurse. If your wife has any troubles in breastfeeding (pain, blocked lactiferous duct...), you should ask doctor for advice • Help your wife to sit or lie in comfortable positions for breastfeeding. • Remind your wife to breastfeed regularly, both day and night, at least 8 times per day. • Do not buy formula to feed the baby. • If you or your wife is worried that the baby is not getting enough milk, talk to the doctor. Usually just feeding more often will cause mother to make enough milk for baby. • Do not feed baby any extra food and drink except breast milk. Breast milk has enough food for your baby and protects your baby from illness better if it is not mixed with other food. • Work as a team with your wife to take care of the baby. Bring your wife water or a snack while she is feeding the baby. Hold the baby while your wife is eating. • Discuss with you wife about good ways for you to spend time with your baby, such as changing diapers, bathing the baby, holding the baby, talking and singing, playing with the baby, etc. • Refer to Father-Infant Relationship calendar for ideas of what to do with the baby
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		<ul style="list-style-type: none">• Babies easily get tired of playing. You will know your baby has played enough when your baby stops looking or turns away.• Note the importance of understanding that the baby's cries are ways of communicating. Babies do not cry because they are trying to irritate you or be naughty. It can be frustrating when your baby cries but it is not good to be strict or harsh with a baby.• All will make your wife feel relax and happy, and help to warm up your family.• Help your wife with housework, take care of the baby so that your wife can sleep and rest more. This helps to keep her healthy and enrich the milk supply.• Avoid having sex within the first six weeks after delivering. This may cause trauma and get infected because your wife has not been extremely recovered after the delivery.
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<p>42 days after birth</p>	<ul style="list-style-type: none"> • Mother's body is coming back to normal. She has adapted with parenting and taking care of the baby. • Baby nurses more and gains more weight • Baby can track moving objects, talking people. • Baby will bat at colorful objects. • Baby starts cooing. • Sleep more at night than day. 	<ul style="list-style-type: none"> • Remind your wife to breastfeed regularly, both day and night, at least 8 times per day. It is good if your baby wants to feed even more often some days—when babies are growing quickly, they sometimes need to make more breastmilk. • Work together with your wife to do the housework. Take care of the baby so that your wife can rest more. This helps to enrich the milk supply. • If your baby cries at nights, decide together how the two of you want to share caring for your baby. • Do not buy formula milk to feed the baby. • Do not feed your baby any extra food and drink except breast milk. Breastmilk will provide everything that your baby needs to grow and be healthy. • Keep your relationship with your wife strong. Spend time together. Encourage each other. Reduce stress in your couple life, as it is one of the factors that affects mother's milk production. • Negotiate with your wife about when to engage in sexual relations and be sensitive to how she is feeling (e.g. she may be too fatigued or physically uncomfortable). • Refer to Father-Infant Relationship Calendar. Ask father for ideas of what he could do with his baby in the next two months, based on what baby will begin doing.
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		<ul style="list-style-type: none">• Talk to your baby and wait for your baby to respond with a sound or face movements. Your baby will look at your face. Watch your baby's face and imitate your baby.• Show your baby interesting and colourful objects—babies do not need toys—things in the house will do.• Try baby aerobics. Gently move baby's arms in and out and then legs up and down. Talk or sing while you move baby.• Try baby massage.• Remember that babies get tired of playing and will turn away, make a face, or begin to cry when she needs to rest.• Your baby will love to be cuddled and carried around. This will help your baby feel safe and happy.• Babies do not try to be naughty. A father does not need to be strict with a baby. Being strict or punishing can hurt your baby and slow your baby's development.
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3.5 months after birth	<ul style="list-style-type: none"> • Mother is fully recovered and can do things as normal. • Baby nurses more, grows fast. His weight can be 1.5 times higher than that when he was born. • Baby can roll over, play more, grab things. • Baby smiles, makes sounds like ma or ba, can imitate sounds, laughs. 	<ul style="list-style-type: none"> • Create favorable conditions for your wife to take adequate rest and diet. Decide together how to share housework. Take care of the baby so that your wife can rest more. These help to enrich the milk production. • If your baby cries at nights, you should help your wife to take care of him. • Encourage your wife to breastfeed as much as your baby wants, both day and night. It is good if your baby wants to feed even more often some days—when babies are growing quickly, they sometimes need to make more breastmilk. Your baby will likely still want to breastfeed 8 or more times/day. Every baby is different. • Help your wife to EXCLUSIVELY BREASTFEED during the first six months without any formula milk or additional food. • Keep your relationship with your wife strong. Spend time together. Encourage each other. Reduce stress in your couple life, as it is one of the factors that affects mother's milk production. • If your wife has to come back to work after 4 months, encourage her to hand express her milk and leave it at home while she is at work, use cup and spoon to feed your baby. • If your wife is going back to work at or before 6 months, do not prepare by offering formula milk or other foods. • Take your baby to vaccinate.
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		<ul style="list-style-type: none">• Convince grandparents and other members in the family to support the mother in exclusive breastfeeding in the first six months.• Refer to Father-Infant Relationship Calendar. Ask father for ideas of what he could do with his baby in the next two months, based on what baby will begin doing.• Pay attention to your baby and respond to what your baby likes to do.• Your baby likes to hold interesting objects like a ball, a stuffed animal, a book made of cloth, or a plastic cup. Babies put everything in their mouths, so make sure the toys or objects are clean, not sharp, and are too big to choke on.• Play with your baby on a blanket on the floor.• Walk around with your baby or look in a mirror together. Talk about what you see and do. Remember to take turns and let your baby “talk” with you.• A baby does not try to be naughty. If your baby is doing something dangerous, gently help your baby do something different. There is never a need to slap or hit a baby.
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Appendix D

Commune Health Worker Questionnaire**Introduction**

In this questionnaire we would like you to answer questions that will help us evaluate the training you received to provide client focused father involvement consulting. Please read each question carefully. Some of the questions will ask about your positive perceptions and some of the questions will ask about your negative perceptions.

Definition of “Client focused father involvement consulting”

Client focused father involvement consulting is defined as non-directive counseling that focuses on the fathers’ needs, encourages the fathers to give their own ideas, and enables the fathers to make their own informed decisions about involvement in breastfeeding and in having a relationship with their infants.

Demographics (please circle one answer)

1. What is your profession?
 Nurse
 Midwife
 Physician
 Physician’s Assistant
 Other (please specify) _____
2. What is your education level?
 Training school
 College
 University
3. How many years did you attend school after high school?
4. What is your age?
5. What is your gender?
 Female
 Male
6. Did you participate in a consulting visit with a pilot father in which you were observed by a member of the research team?
 Yes
 No

If yes, which consulting visits were observed?

I. Your perceptions about the training workshop

Below is a list of statements related to the training workshop you attended about father involvement in breastfeeding. Please read the following statements carefully. On each one, you will need to give your opinion (indicating the **level of your agreement**) by circling a number from 1 to 7 corresponding to your opinion.

No.	Question	Strongly Disagree			Neutral			Strongly Agree
1	The counsellor training workshop gave me the information I needed to provide counseling about father support of breastfeeding and father-infant relationships.	1	2	3	4	5	6	7
2	The counsellor training workshop increased my confidence in my ability to provide client focused consulting to fathers about involvement in breastfeeding and in relating to their infants.	1	2	3	4	5	6	7
3	Watching a group counselling session at the training workshop increased my confidence in my ability to provide counselling to fathers about involvement in breastfeeding and relating to their infants.	1	2	3	4	5	6	7
4	Meetings with research team members at the training workshop increased my confidence in my ability to provide client focused consulting for fathers.	1	2	3	4	5	6	7

5	Group discussions at the training workshop helped me think about my own beliefs about father involvement.	1	2	3	4	5	6	7
6	The power point slides at the training workshop were a facilitator to my learning about client focused father involvement consulting.	1	2	3	4	5	6	7
7	The discussion at the training workshop was a facilitator to my learning about client focused father involvement consulting.	1	2	3	4	5	6	7
8	The location and environment of the training workshop were facilitators to my learning about client focused father involvement consulting.	1	2	3	4	5	6	7
9	I would have liked more role play during the training workshop.	1	2	3	4	5	6	7
10	I would have liked more learning based on observation at the training workshop.	1	2	3	4	5	6	7
11	Work commitments made it difficult for me to attend the training workshop.	1	2	3	4	5	6	7
12	Family life made it difficult for me to attend the training workshop.	1	2	3	4	5	6	7
13	Travel distance made it difficult for me to attend the training workshop.	1	2	3	4	5	6	7
14	The counsellor training manual gave me the information I needed to provide client focused father involvement consulting.	1	2	3	4	5	6	7

II. Your perceptions about the pilot father practice counseling experience

Below are statements related to the pilot father practice counseling you experienced. Please read the following statements carefully. On each one, you will need to give your opinion (indicating the **level of your agreement**) by circling a number from 1 to 7 corresponding to your opinion.

If you **did not participate** in this experience please do not answer this question. Please check mark here instead:

☐

No.	Question	Strongly Disagree			Neutral			Strongly Agree
1	Being observed providing counselling to a pilot father increased my confidence.	1	2	3	4	5	6	7
2	Talking to a research team member after the pilot father consulting sessions increased my confidence.	1	2	3	4	5	6	7

III. Your perceptions about the overall learning and consulting experience

Below is a list of statements related to the overall learning experience about father involvement in breastfeeding. Please read the following statements carefully. On each one, you will need to give your opinion (indicating the **level of your agreement**) by circling a number from 1 to 7 corresponding to your opinion.

No.	Question	Strongly Disagree			Neutral			Strongly Agree
1	The involvement of supervisors and district health staff in the training made me feel supported in providing father involvement consulting.	1	2	3	4	5	6	7
2	The support of my workplace makes me feel more confident in my ability to provide client focused consulting to fathers	1	2	3	4	5	6	7

	about involvement in breastfeeding and relating to their infants.							
3	Fatigue made it difficult to learn new knowledge about providing client focused father involvement consulting.	1	2	3	4	5	6	7
4	Personal stress made it difficult to learn new knowledge about providing client focused father involvement consulting.	1	2	3	4	5	6	7
5	Work schedules of the fathers made providing home visits for father involvement consulting difficult.	1	2	3	4	5	6	7
6	Work schedules of the fathers made providing group counselling difficult.	1	2	3	4	5	6	7
7	Providing client focused father involvement consulting is stressful.	1	2	3	4	5	6	7

IV. Your goals for providing client focused father involvement consulting

Below is a list of statements related to your goals for providing client focused father involvement consulting. Please read the following statements carefully. On each one, you will need to give your opinion indicating how often you do, or plan to do, that item by circling a number from 1 to 7 corresponding to your opinion.

No.	Question	Not at all			Neutral			Always
1	I plan to provide client focused father involvement consulting.	1	2	3	4	5	6	7
2	I plan to continue to learn new knowledge related to father involvement in breastfeeding.	1	2	3	4	5	6	7
3	I plan to provide non-directive consulting that focuses on fathers' needs.	1	2	3	4	5	6	7

4	I plan to help fathers set their own goals for involvement in breastfeeding.	1	2	3	4	5	6	7
5	I reflect on my practice to promote client focused father involvement consulting.	1	2	3	4	5	6	7
6	I feel motivated to provide client focused father involvement consulting.	1	2	3	4	5	6	7

V. Your perceptions on feelings of confidence

Below is a list of statements related to your feelings of confidence in providing client focused father involvement consulting. Please read the following statements carefully. On each one, you will need to give your opinion (indicating the **level of confidence**) by circling a number from 1 to 7 corresponding to your opinion.

No.	Question	Not at all confident			Neutral			Very confident
1	How confident are you that you can effectively counsel fathers about involvement in breastfeeding and in developing a healthy relationship with their infants?	1	2	3	4	5	6	7
2	How confident are you that you can provide client focused father involvement consulting?	1	2	3	4	5	6	7
3	How confident are you that you will continue to use client focused consulting with different clients in the future?	1	2	3	4	5	6	7
4	How confident are you that you can overcome any problems you may encounter with practicing client focused consulting?	1	2	3	4	5	6	7

VI. Your beliefs and feelings about client focused father involvement consulting and father involvement.

Below is a list of statements related to your beliefs and feelings about client focused father involvement consulting and father involvement. Please read the following statements carefully. On each one, you will need to give your opinion (indicating the **level of your agreement**) by circling a number from 1 to 7 corresponding to your opinion.

No.	Question	Strongly Disagree			Neutral			Strongly Agree
1	I have greater impact on father-infant involvement when I practice client focused consulting.	1	2	3	4	5	6	7
2	I have greater impact on breastfeeding rates and duration when I practice client focused consulting to support father involvement in breastfeeding.	1	2	3	4	5	6	7
3	I will be able to sustain this practice of client focused father involvement consulting over time.	1	2	3	4	5	6	7
4	Practicing client focused father involvement consulting makes me feel more satisfied in my job.	1	2	3	4	5	6	7
5	I feel a sense of self-worth when I practice client focused father involvement consulting.	1	2	3	4	5	6	7
6	It is important for me to be rewarded by my local and district supervisors for providing client focused father involvement consulting.	1	2	3	4	5	6	7
7	As a result of this education, I now believe more strongly than I did before that exclusive breastfeeding is the right thing to do.	1	2	3	4	5	6	7
8	As a result of this education, I now believe more strongly than I did before that involving fathers in breastfeeding is the right thing to do.	1	2	3	4	5	6	7

9	As a result of this education, I now believe more strongly than I did before that fathers should be more involved in a relationship with their infants.	1	2	3	4	5	6	7
10	As a result of this education, I now believe more strongly than I did before that practicing client focused consulting is the right thing to do.	1	2	3	4	5	6	7

VII. Your practice of providing client focused father involvement consulting

Below is a list of statements related to your current practice of providing client focused father involvement consulting. Please read the following statements carefully. On each one, you will need to give your opinion, indicating how often you do this item, by circling a number from 1 to 7 corresponding to your opinion.

No.	Question	Not at all			Neutral			Always
1	Since this education, I provide more client focused consulting for fathers than I did before.	1	2	3	4	5	6	7
2	I ask fathers for their ideas about involvement in breastfeeding.	1	2	3	4	5	6	7
3	I add information to my consulting sessions based on what fathers ask or tell me.	1	2	3	4	5	6	7
4	I help fathers to be able to make their own decisions about their involvement.	1	2	3	4	5	6	7
5	I help fathers to find solutions to questions about father involvement.	1	2	3	4	5	6	7
6	I show fathers that I respect their ideas and decisions.	1	2	3	4	5	6	7
7	I focus on fathers' needs when I consult with them.	1	2	3	4	5	6	7
8	I help fathers to make a plan for their involvement.	1	2	3	4	5	6	7

9	I <u>directly tell</u> fathers what to do to be involved in breastfeeding or with their infants.	1	2	3	4	5	6	7
10	I <u>directly tell</u> fathers what goals they should have for involvement in breastfeeding.	1	2	3	4	5	6	7

Appendix E

Verbal Script

Greetings, etc

I am going to all the communes involved in the Father Involvement study to speak with all of the Commune Health Workers who have attended the training sessions. I have a questionnaire that the research team would appreciate if you would complete. We have a graduate student from Canada that has created this questionnaire to help us evaluate the education about father involvement. We are hoping you will fill this out as it will help us to plan for future education. The questionnaire will ask you your thoughts about the training session days, the pilot father observations sessions (if you did those) and your current practice. This should take about 30 minutes of your time. You do not have to fill this out and you can withdraw any time while you are completing the questionnaire. If you do fill this out, when you are finished you can place it in this envelope and seal it. That way I will not see your answers and your answers will remain anonymous. Also, we do not want you to put your name on this since it should remain anonymous. Your questionnaire will be kept in a locked cabinet at the Hanoi School of Public Health until the information is put into a computer system. When we are done with the information we will destroy the questionnaires.

Thanks so much for being willing to do this.

Appendix F

Letter of Invitation

January, 2015

Title of Study: The perceptions of commune health workers about education strategies received for counselling fathers about infant and breastfeeding involvement

Principal Investigator: Lynn Rempel, RN, Ph.D., Associate Professor
Department of Nursing, Brock University

Vietnam Co-investigator: Tran Huu Bich, Vice Dean, Research
Department of Epidemiology, Hanoi School of Public Health

Student Principal Investigator: Stephanie Pyke, RN, BScN, MA (candidate)
Department of Nursing, Brock University

I, Stephanie Pyke, RN, BScN, MA in Applied Health Sciences (candidate) from the Department of Nursing, Brock University, invite you to participate in a research project entitled “The perceptions of commune health workers about education strategies received for counseling fathers about infant and breastfeeding involvement”.

The purpose of this research project is to examine your perceptions about the training process in which you participated to learn about counselling fathers on involvement with infants and breastfeeding. This includes the workshops, training manuals and pilot father interactions in which you participated as part of the “Father Involvement: Saving Brains in Vietnam” study. Should you choose to participate, you will be asked to complete a survey which will ask you questions about this process. You will also be asked about your father involvement counselling practices.

This process should take 30 minutes of your time.

This research will help the “Father Involvement” research team to plan further training strategies. This research will also benefit other organizations planning education for health care workers about father involvement.

If you have any comments, or concerns, or questions about your involvement in the project, please contact the Hanoi School of Public Health Research Ethics Office [177/2015/YTCC-HD3] at 84.4.62662329 or the Brock University Research Ethics Office [REB 14-166] at reb@brocku.ca.

If you have any questions, please feel free to contact me (see below for contact information).

Thank you,

Stephanie Pyke, BSc.N, MA in Applied Health Sciences (Candidate)
Department of Nursing
Brock University, St. Catharines, ON, Canada
sp13uy@brocku.ca
905-295-7132

Lynn Rempel, RN, Ph.D., Associate Professor
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Tran Huu Bich, Vice Dean, Research
Department of Epidemiology
Hanoi School of Public Health
Hanoi, Viet Nam
0913515710
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This study has been reviewed and received ethics clearance through the Research Ethics Board at Hanoi School of Public Health, the Research Ethics Board at Brock University.

Appendix G

Informed Consent

Date: January, 2015

Project Title: The perceptions of commune health workers about education strategies received for counselling fathers about infant and breastfeeding involvement

Principal Investigator: Lynn Rempel, RN, Ph.D., Associate Professor
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INVITATION

You are invited to participate in a study that involves research. The purpose of this study is to examine the perceptions of commune health workers about the training received to counsel fathers about involvement with infants and breastfeeding.

WHAT'S INVOLVED

As a participant, you will be asked to complete a survey that will ask you about your perceptions of the training sessions, training manual, and pilot father interactions. Participation will take approximately 30 minutes of your time.

POTENTIAL BENEFITS AND RISKS

Possible benefits of participation include the opportunity for reflection about the training process and about your practice of client focused consulting. There are no known or anticipated risks associated with participation in this study.

CONFIDENTIALITY

All information you provide is considered confidential; your name will not be included or, in any other way,

associated with the data collected in the study. Furthermore, because our interest is in the average responses of the entire group of participants, you will not be identified individually in any way in written reports of this research.

Data collected during this study will be stored in locked filing cabinets at Hanoi School of Public Health. Data will be kept for the length of the study after which time questionnaires will be destroyed.

Access to this data will be restricted to research team members.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you wish, you may decline to answer any questions or participate in any component of the study. Further, you may decide to withdraw from this study at any time while you are completing the questionnaire and may do so without any penalty or loss of benefits to which you are entitled.

PUBLICATION OF RESULTS

Results of this study may be published in professional journals and presented at conferences. Feedback about this study will be provided to research team members at Hanoi School of Public Health. Please contact team members using information listed above.

CONTACT INFORMATION AND ETHICS CLEARANCE

If you have any questions about this study or require further information, please contact **Dr. Rempel, Dr. Bich or Ms. Pyke** using the contact information provided above. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University [REB 14-166] and Hanoi School of Public Health [177/2015/YTCC-HD3]. If you have any comments, or concerns, or questions about your involvement in the project, please contact the Hanoi School of Public Health Research Ethics Office at 84.4.62662329, the Brock University Research Ethics Office at reb@brocku.ca

Thank you for your assistance in this project. Please keep a copy of this form for your records.

CONSENT FORM

I agree to participate in this study described above. I have made this decision based on the information I have read in the Information-Consent Letter. I have had the opportunity to receive any additional details I wanted about the study and understand that I may ask questions in the future. I understand that I may withdraw this consent at any time.

Name: _____

Signature: _____ Date: _____

Appendix H

CHW Questionnaire Organized by SCT Variables

Introduction:

In this questionnaire we would like you to answer questions that will help us evaluate the training you received to provide client focused father involvement consulting. Please read each question carefully. Some of the questions will ask about your positive perceptions and some of the questions will ask about your negative perceptions.

Definition of “Client focused father involvement consulting”:

Client focused father involvement consulting is defined as non-directive counseling that focuses on the fathers’ needs, encourages the fathers to give their own ideas, and enables the fathers to make their own informed decisions about involvement in breastfeeding and in having a relationship with their infants.

Demographics (please circle one answer)

1.What is your profession?

Nurse
Midwife
Physician
Physician’s Assistant
Other (please specify) _____

2.What is your education level?

Training school
College
University

3.How many years did you attend school after high school?

4.What is your age?

5.What is your gender?

Female
Male

6.Did you participate in a consulting visit with a pilot father in which you were observed by a member of the research team?

Yes
No

If yes, which consulting visits were observed?

Theory Variables:

Self-Efficacy (1-7 scale, 1 being ‘not at all confident’ and 7 being ‘very confident’)

1. How confident are you that you can effectively counsel fathers about involvement in breastfeeding and in developing a healthy relationship with their infants?
2. How confident are you that you can provide client focused consulting?
3. How confident are you that you will continue to use client focused consulting with different clients in the future?
4. How confident are you that you can overcome any problems you may encounter with practicing client focused consulting?

Self-Efficacy (1-7 scale, 1 being ‘strongly disagree’ and 7 being ‘strongly agree’)

5. The counsellor training workshop gave me the information I needed to provide counseling about father support of breastfeeding and father-infant relationships.
6. The counsellor training manual gave me the information I needed to provide client focused father involvement consulting.
7. The counsellor training workshop increased my confidence in my ability to provide client focused consulting to fathers about involvement in breastfeeding and in relating to their infants.
8. Watching a group counseling session at the training workshop increased my confidence in my ability to provide counseling to fathers about involvement in breastfeeding and relating to their infants.
9. I would have liked more role play during the training workshop.
10. I would have liked more learning based on observation.
11. Being observed providing counseling to a pilot father increased my confidence.
12. Talking to a research team member after the pilot father consulting sessions increased my confidence.
13. The involvement of supervisors and district health staff in the training made me feel supported in providing father involvement consulting.
14. The support of my workplace makes me feel more confident in my ability to provide client focused consulting to fathers about involvement in breastfeeding and relating to their infants.
15. Meetings with research team members increased my confidence in my ability to provide client focused consulting for fathers.

16. Group discussions at the training workshop helped me think about my own beliefs about father involvement.
17. Providing client focused father involvement consulting is stressful.

Outcome Expectations (1-7 scale, 1 being ‘strongly disagree’ and 7 being ‘strongly agree’)

1. I have greater impact on father-infant involvement when I practice client focused consulting.
2. I have greater impact on breastfeeding rates and duration when I practice client focused consulting to support father involvement in breastfeeding.
3. I will be able to sustain this practice of client focused father involvement consulting over time.
4. Practicing client focused father involvement consulting makes me feel more satisfied in my job.
5. I feel a sense of self-worth when I practice client focused father involvement consulting.
6. It is important for me to be rewarded by my local and district supervisors for providing client focused father involvement consulting.
7. As a result of this education, I now believe more strongly than I did before that exclusive breastfeeding is the right thing to do.
8. As a result of this education, I now believe more strongly than I did before that involving fathers in breastfeeding is the right thing to do.
9. As a result of this education, I now believe more strongly than I did before that fathers should be more involved in a relationship with their infants.
10. As a result of this education, I now believe more strongly than I did before that practicing client focused consulting is the right thing to do.

Sociostructural Factors (1-7 scale, 1 being ‘strongly disagree’ and 7 being ‘strongly agree’)

1. Work commitments made it difficult for me to attend the training workshop.
2. Family life made it difficult for me to attend the training workshop.
3. Travel distance made it difficult for me to attend the training workshop.
4. Fatigue made it difficult to learn new knowledge about providing client focused father involvement consulting.
5. Personal stress made it difficult to learn new knowledge about providing client focused father involvement consulting.
6. Work schedules of the fathers made providing home visits for father involvement consulting difficult.
7. Work schedules of the fathers made providing group counseling difficult.

8. The power point slides were a facilitator to my learning about client focused father involvement consulting.
9. The discussion was a facilitator to my learning about client focused father involvement consulting.
10. The location and environment of the training workshop were facilitators to my learning about client focused father involvement consulting.

Goals (1 to 7 scale, 1 being ‘not at all’ and 7 being ‘always’)

1. I plan to provide client focused father involvement consulting.
2. I plan to continue to learn new knowledge related to father involvement in breastfeeding.
3. I plan to provide non-directive consulting that focuses on fathers’ needs.
4. I plan to help fathers set their own goals for involvement in breastfeeding.
5. I reflect on my practice to promote client focused father involvement consulting.
6. I feel motivated to provide client focused father involvement consulting.

Behaviour (1-7 scale, 1 being ‘not at all’ and 7 being ‘always’)

1. Since this education, I provide more client focused consulting for fathers than I did before.
2. I ask fathers for their ideas about involvement in breastfeeding.
3. I add information to my consulting sessions based on what fathers ask or tell me.
4. I help fathers to be able to make their own decisions about their involvement.
5. I help fathers to find solutions to questions about father involvement.
6. I show fathers that I respect their ideas and decisions.
7. I focus on fathers’ needs when I consult with them.
8. I help fathers to make a plan for their involvement.
9. I directly tell fathers what to do to be involved in breastfeeding or with their infants.
10. I directly tell fathers what goals they should have for involvement in breastfeeding.

Appendix I

Feedback Letter

Dear Participant,

Thank you for your participation in this father involvement training evaluation. This is a very important study to help with the understanding of education for healthcare workers about father involvement. The items you answered in the questionnaire will help us to understand which factors in an education strategy for healthcare workers are most effective in promoting client focused father involvement consulting. In order to determine this, we asked questions about how often you provide, or plan to provide, client focused father involvement consulting. We also asked questions about facilitators and barriers to the training process, your confidence level in providing this consulting, and your beliefs about father involvement and consulting.

Most of you found the education sessions helpful in learning about father involvement. You told us that the power point slides, group discussion, group counselling sessions, and meetings with the educators were very helpful. You told us that, after the father involvement training, you had greater confidence in your ability to provide father involvement consulting, had more positive beliefs that breastfeeding and father involvement were important, were providing client focused father involvement consulting and had plans to continue this consulting practice.

The results of this study will be used to help plan, and implement, further father involvement healthcare worker education strategies, both in Vietnam and worldwide. If the father involvement study through Hanoi School of Public Health is expanded, this information will be very valuable. Practicing client focused father involvement consulting will greatly impact the families you work with, as well as breastfeeding rates in your region. Your input about education strategies for healthcare workers about client focused father involvement consulting will impact the future of healthcare education and father involvement in general.

If you would like to receive details of the results of this study, please contact myself or Dr. Lynn Rempel using the contact information below.

Thank you,

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